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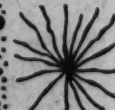
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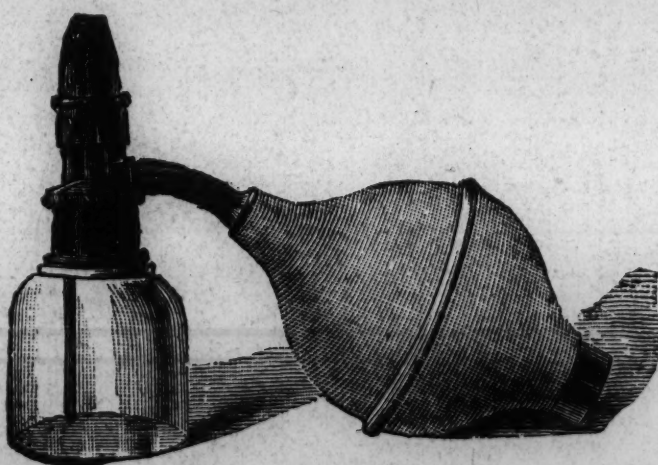


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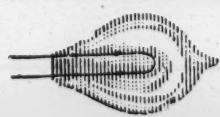
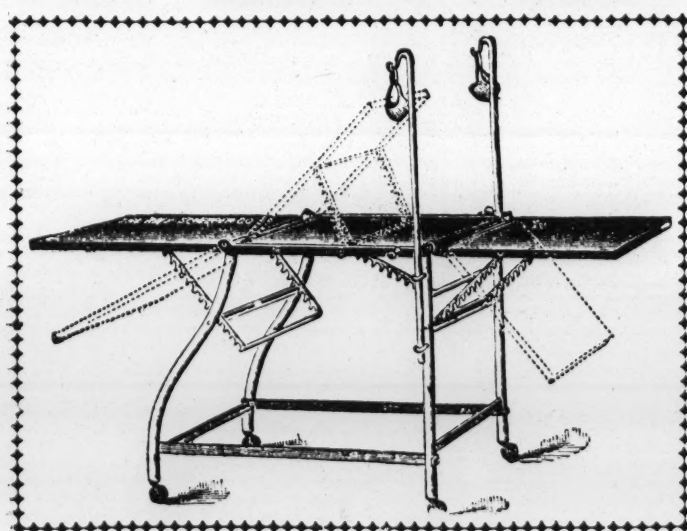
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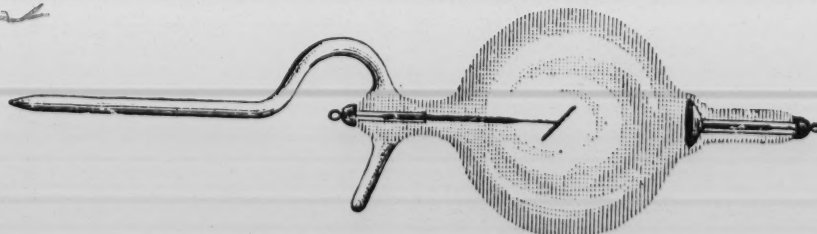
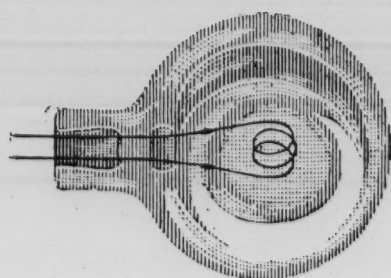
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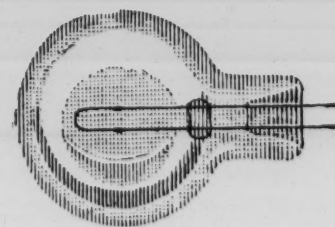


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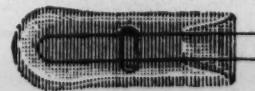
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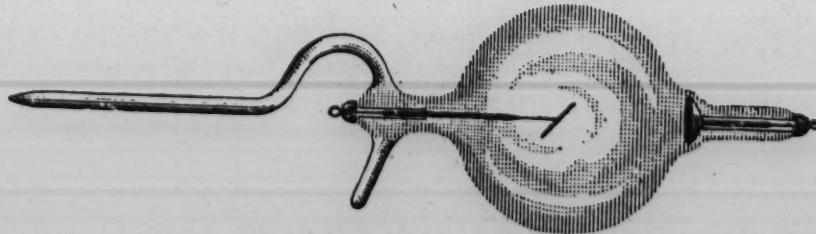
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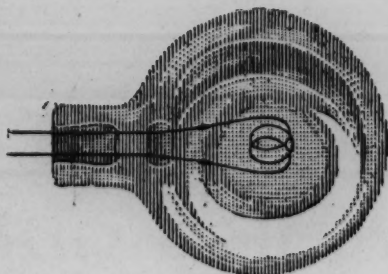
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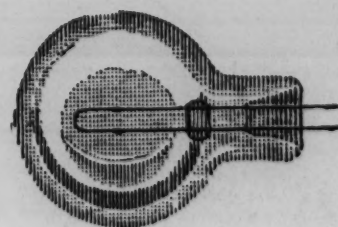
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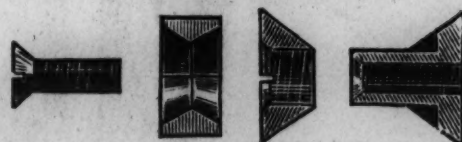
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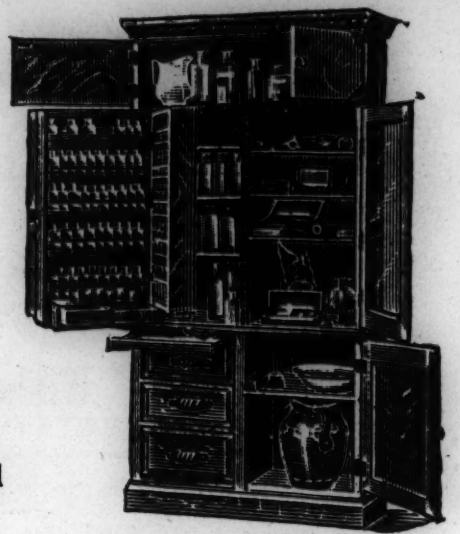
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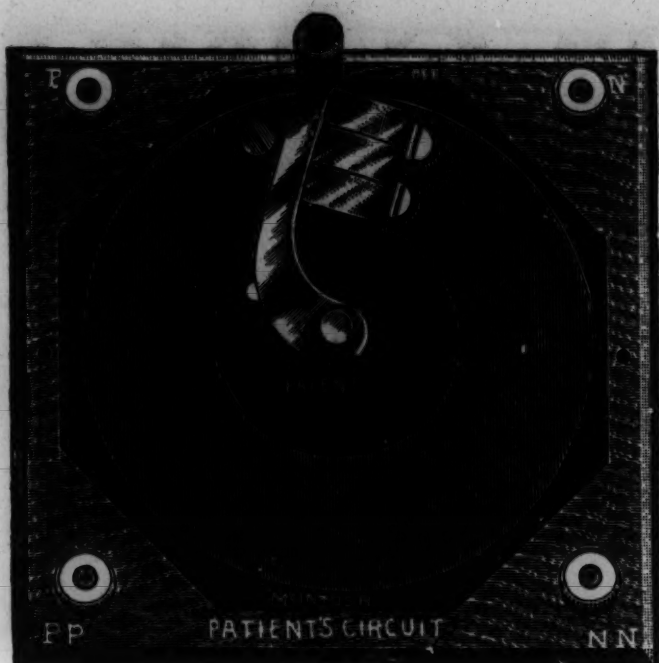
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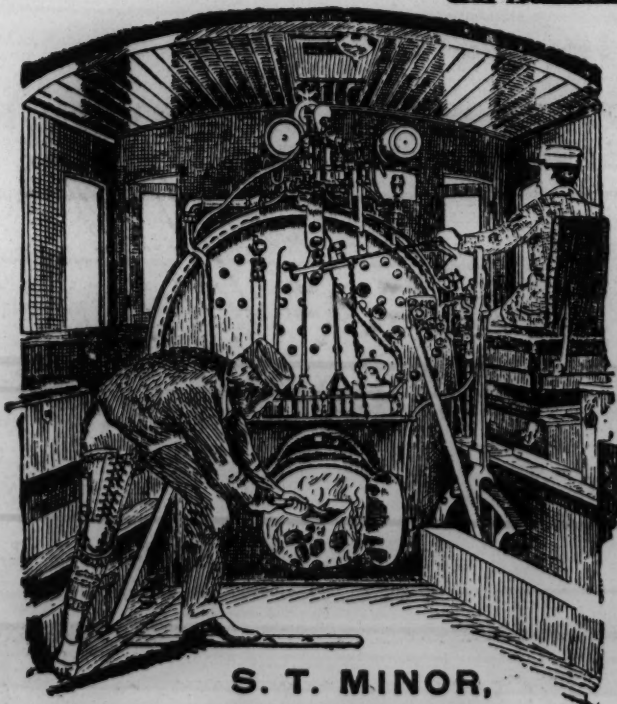
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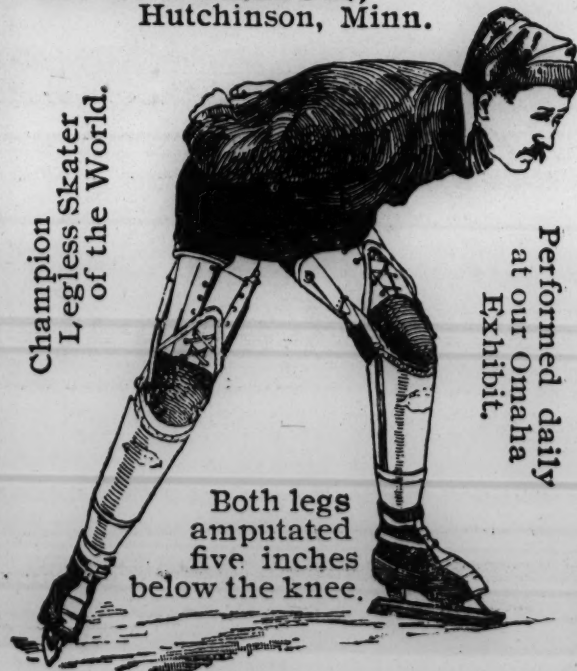
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# Occidental Medical Times

VOLUME XIII.

SAN FRANCISCO, SEPTEMBER 15, 1899.

NUMBER 9.

## AN ADDRESS.

BY RABBI JACOB VOORSANGER.

Delivered at Commencement Exercises of Cooper Medical College Aug. 22, 1899.

Mr. President, Ladies and Gentlemen of the Graduating Class: The entrance into active life of a number of well trained young men and women is always an occasion for both congratulation and serious contemplation. Society can never have too many competent public servants in the professions if we properly emphasize the competency and couple with it the paramount conditions of character and integrity. Hence the congratulation, so far as this presence is concerned. The judgment of this learned faculty, composed of eminent public men, masters in special departments of knowledge, is held in this community to be competent to decide whether this class of graduates can be entrusted with the grave responsibilities inherent in the medical profession. It is to be presumed, as a consequence of the great confidence reposed in these eminent men, that both your fitness and your character have been gravely and seriously weighed in the balance, and that you have not been found wanting; for such as they hold human life to be very precious and they would not incautiously expose it to the danger of incompetent practitioners. Therefore, ladies and gentlemen, you are to be sincerely congratulated upon this notable expression of confidence on the part of great and learned preceptors, who have subscribed their signatures to a public testimony that society may trust you; that you are in possession of those noble secrets by which the initiate can wrestle with death-dealing disease, and

that your judgment can be relied upon to assist nature in her constant and loyal processes of equilibration. To that extent, assuredly, your entrance into the activities of life marks an epoch in the history of civil society; to that extent this day is memorable to you, to us, your future patients and to the community at large.

But, on the other hand, ladies and gentlemen, your accession to the duties and responsibilities of the most exalted profession on earth arouses in a seriously disposed mind certain considerations which I must not withhold from you, lest the tone of my felicitations might sound insincere and lest you and I might be convicted of inadequately appreciating the gravity of this occasion and moment. Generally I look upon a class of graduates with some degree of concern. They swell the ranks of the workers and demand a share, a legitimate share, of the business in which they are to engage. Might I not submit the question to you whether your profession has any ideals? I ask in no carping spirit, I beg to assure you. Some years ago an eminent practitioner told me that, to him, the practice of medicine was simply a means of acquiring independence, so that thereafter he might undisturbedly devote himself to the pursuit of his favorite sciences. So far as that gentleman is concerned, I can understand the statement. Practical professional cares are too often a hindrance to the pursuit of knowledge. Great discoveries come as often from the laboratories as from the hospital or the sick room. But, as a general statement, my friend's assertion might apostrophize one of the growing evils of professional



life, the evil of commercialism; the evil of selecting a profession, not for its eloquent suggestion to the student to delve in nature's gold mines, not for the eminent humanitarian aspects with which every profession is endowed, but the so-called professional man standing as a fee-gatherer, a money-maker, whose income grows with his popularity and the number of his patients and clients. Now that you are, by the vote of your faculty and the consent of the board of directors, physicians in full standing, would it be offensive to ask you the question: Why did you choose this profession? What is your purpose—what is the ideal that underlies your choice? These questions are pertinent. If in your choice of profession you hit merely upon one you fancied would pay well, it must be admitted that your ideal is a very low one. If, sitting at the hearthstones of your preceptors you have caught some of their fire, or, if wandering 'neath the porticos of halls of science your wistful gaze has longingly beheld the inner sanctuary, and the yearning came over you to know all its secrets, to give your lives to the service of that which is the constitutional warrant of all science and all knowledge—the happiness of mankind, then you will grow up and grow old to condemn, as I do most severely, the commercialism that multiplies the number of professional men far beyond the normal needs of society. Professions must never be confounded with trades. Neither the physician's nor the clergyman's service is to be interpreted as a commodity, to be valued by the rise and fall of the market. To be sure, the physician is, like any other laborer, worthy of his hire; but, let it be understood that in the noblest sense of his profession his aim is not the hire. His is, or should be, a higher mission. \* \* \* Standing

in this hall and in this revered presence, I am encouraged that my ideals are not the flimsy fabric of an impractical vision, but the capable suggestions underlying the practical interpretation of true professional service; a service in which the individual with all his eminent capacities, with all the wealth of knowledge and the strength of his accomplishments, subordinates himself to the one condition that warrants his joining the ranks of the esoterists, and that one condition is the happiness of society. With Dr. Lane before us as a living example we may be convinced that even now the ideals of the medical profession are not dead!

Why do I say "even now?" Because, gentlemen, at times we have reason to suspect that commercialism is getting the upper hand in all professional life. We are, in our own day and generation, confronting curious problems that sooner or later will need adjudication, lest they imperil the peace of society. Without going into figures, it may be stated as a general fact that the number of professionals in this city and State, as well as throughout the country, is entirely disproportionate to the number actually needed. What, may I ask, causes this rapid, unwholesome multiplication? I am answered, in one direction, that education and the evolutions of modern society are themselves responsible for it. Education is diffuse; it is no longer the prerogative of rank or class. \* \* \* That the world is advancing from intellectual semi-darkness into the glare of knowledge can only assist the main cause of existence—happiness. But this trooping together of many hosts beneath the standards of knowledge has also had a tendency of creating in many people a false impression that they are called to fields of intellectual or professional



labor; that the gentler character of the professions is an attractive inducement to shun the more severe conditions of labor and trade; and that "making a living" as a gentleman is to be preferred to toiling like a boor. I doubt whether this drastic contrasting of two extremes covers the contention it is here intended to present; the fact is, that between these two extremes lie a number of opinions, or so-called opinions, why professional life should be preferred. One fact seems to be absolutely true; that the multiplication of professional colleges, which may be in part attributed to the multiplication of students, has tended to cheapen science and to lower the standard of knowledge. I asseverate that I speak in no carping spirit, aim my shafts at no institution, seek to assail no opinion, or any school founded upon a dissenting opinion, or principle; I state what I believe to be a fact, and if I prove to be in error I should gladly confess it, for on this delicate question I would wish to be mistaken. Let me repeat that the dissemination of knowledge is no reason why people should seek entrance into professional life. The motive for such entrance should be the call—the call from the summit of the mountain of knowledge, along the paths of which so many are ambitiously stumbling only to realize at last that there is no summit for them. It is discouraging to see so many climb in vain the steep heights, under the mistaken impression that the top can be easily reached. Gentlemen, nothing in life is more difficult to attain than professional success. It demands penalties that few can afford to pay, few have the courage to pay. It demands absolute self-abnegation; a consecration to duty conditioned by no commercial consideration; a constant, perpetual worship at the altar of knowledge; a faithful pursuit

of every experience that may contribute to man's happiness. \* \* \* The first condition of success is not repose, but struggle; the first condition of the doctor's success is not the fashionable patient, but his perfect knowledge of the divine machinery of human nature. How many are there who, entering the halls of student life, do so endeavor to understand the motives of their profession and the ideals of their future careers? I protest that the false notions of the uses of education have generated a dangerous tendency to crowd the professions, and as one result we have a social phenomenon never before known to the same mischievous extent, namely, the professional loafer. Why should every person with a bright mind become a doctor or a lawyer? Why should the folly of parents or the immature conceptions of the demands of science and culture, or the mistaken notions of social standing create this dangerous propensity, that absolutely endangers the honor and dignity of professional life? For, mark you, multiplication in itself may be construed as an evidence of the growth and dissemination of knowledge and education; but in its result it is so mischievous that the premise cannot stand a moment. The result, viewed from the standpoint of practical economics, is to create a surplus commodity, a cheap one at that, which tends to gradually lower the market. Competition naturally sets in; not that competition as to who shall be wisest, who shall achieve most in the fields of science and humanity; the competition resolves itself simply into a question for bread, for with all our ideals bread is the foremost necessity of physical existence. That men should turn to the professions as a means of winning bread is quite natural; but the wrong is that to-day it almost seems as if professions have



fallen to the level of the commonest manual labor. Many men believe that to become physicians is as easy as to become mechanics. They do not seem to realize that a mere ambition to become a professional man counts for nothing; that if it requires brains, culture, ingenuity and education to become a high-class mechanic, the responsibilities of the care of human life can only be confided to those who, despite their ambition, prove to possess the aptitude, the capacity, the scientific acumen and the moral courage to face these responsibilities. I protest that writing nostrums for a fee can easily be learned, but that is not the practice of medicine. I suspect that one can mechanically learn to use knife or lancet, but that is not surgery. The learned professions are not, primarily, avenues for social or financial success, nor even for scientific reputation; these are but consequent conditions. The first motive of the learned profession is to apply knowledge to the needs of humanity; in your instance, to acquire intellectual, scientific, medical and surgical experience adequate to cope with the difficult problems of life that seem even to multiply in our day, for it is true that the more we lift the darkness the thicker it seems to grow. Are these conditions so easy of compass that they should encourage people to knock at the doors of the professions? Would it not seem to any one who takes these matters seriously that one would hesitate and ponder long and deeply to decide whether his intellect, his temperament, his disposition and his ambition all combine to render him fit for preparation for the grave responsibilities of professional service? And yet the rapid multiplication of professionals might prove these questions to be vain and foolish indeed.

They are not; I contend that the ma-

jority of people have no adequate perception of the gravity of choosing a profession. Ambition whispers that they can do what the other man does; ambition flatters their vanity, and many a foolish mother believes her son or daughter to be made of finer fiber than the rest of mankind, hence fit to be a king or queen of men. I believe in my innermost soul that the folly and vanity of ambition have much to do with creating this professional overproduction and affording us the lamentable spectacle of professional men out of employment and compelled, like any cavalier of fortune, to resort to their wits to find bread. For, let me urge again, all the ideality in the world does not obviate the necessary quest for bread. As a rule the professional man is unfit to change his vocation as to the result of necessity; they who have once tasted the fruit of knowledge, be it ever so bitter, will not willingly turn to even pleasanter fruit in other gardens. What is the result? Competition for one thing; a common struggle for bread, a warfare of the survival of the fittest; and for another still more dangerous result, the lowering of professional standards and the prostitution of science to the low practices of the faker and professional swindler. Gentlemen, your profession does not suffer from the peddler who in the open street sells his nostrums, but its dignity and honor are imperiled by the man who advertises in the newspapers: "My diploma hangs in my office." The educated faker, the graduate, who for the sake of success dishonors the ethics of his school, whose knowledge enables him to play on the susceptibilities of suffering mankind, and who gathers in shekels under invocations that insult and dishonor the signatures of his erstwhile masters—he is the man who has become



dangerous to your profession, because he is the product of unbalanced conditions, imperfect legal supervision, and of the deplorable, but utterly human logic, that he who cannot find his bread legitimately will seek it illegitimately. The faker has become one of the ponderous social interrogations of the times. He represents the fallacy that science is all-conquering and superdominating; he represents the certainty that education and enlightenment are not so diffuse as we flatter ourselves; he represents, in fact, the reactionary tendencies of society, willing to hearken to every perversity, to every imposition; willing to pay for every debasement of the aims of science and culture. The faker, dangerous because of his grain of knowledge, is evidence, first of the still crying needs of educating society to a true appreciation of academic education and the conferring of legitimate authority; and secondly, of the fact that in the face of ambition, in the face of chicanery, in the face of unlawful struggle to encompass financial success, appeals to the worst passions, vices and follies will still be made, and professional ethics will be violated and trampled under foot. But, frankly speaking, is the faker to be condemned only for what he is, and not also for the conditions that create him and encourage his existence? Is there nothing to be said of the temptation that besets a physician without a practice, the ambitious man who wears out his courage and patience because the years go by without bringing him an inch nearer his goal? Is there to be no word of caution uttered against that overproduction that crowds the profession with idlers, often half-educated idlers, who, whether idlers are looking for the competency which with or against their wills, nevertheless they justly believe to be

their due? And, is there naught to be said against the encouragement of the faker, the swindler, and the impostor by the multiplication of colleges, so-called, or the law that enables a few men of uncertain degree or standing to organize into a college, obtain a charter and confer degrees without satisfying the high educational demands of our times? Really, gentlemen, is there naught to be said against the factories that grind out doctors after eighteen months of preparation and furnish sheepskins to all the dunces who have failed in other colleges or in any other career? The fact is that every social evil only punctuates social toleration toward evil. The faker who flourishes like a bay tree is but the visible evidence of conditions we tolerate in our midst, and he will continue to prosper, and other signs of degeneration will continue to develop as long as we hold education at a low premium, as long as we do not safeguard the integrity and honor of professional life, and our standards of professional education are not absolutely the highest.

The remedy for every source of evil, here indicated, which will mean the rejuvenation of the high ideals of the medical profession lies in the first place with the medical colleges themselves, that is to say, those of undoubted standing and accredited throughout the world, as competent to send out reputable physicians. They must raise their standards still higher. I believe in the exclusive and aristocratic character of the professions. I believe that the test of admission to them should be very severe. The people require protection not only against imposture, but against incompetency, though often these words are synonymous. I believe that much overcrowding, and consequently much incompetency, much professional anarchy and



much imposition may be avoided by making plain at the outset to the candidate for professional life that his admission to the training school opens up sources of education for which he must be mentally qualified. In other words, and with proper respect to this venerable presence, I submit that our standards of admission are still too low. The conditions of entering the professions, above all the medical profession, must be of the most severe character. They must be commensurate with the responsibility the student will be called upon to assume. I ask leave here, and at this time, to briefly enumerate the conditions upon which I believe the foundation and government of every medical school should rest, and by which the dignity and the interest of the medical profession could be enhanced. You will understand that, being a layman, I view this matter purely from a general educational standpoint and with a view to the interests of society, the greatest gainer or loser in these matters.

Society demands that the number of students be contracted by the raising of educational standards and the enactment of laws prohibiting undue multiplication.

First—Every medical school should be a post-graduate institution, and every degree conferred by it should be the highest academic distinction.

Second—The body of students should be post-graduates, and the standard of admission should be, either a diploma from a university with testimony of having attending scientific courses, or an examination for admission should be equal to the final examination of the senior year of university life.

Third—A State law should prohibit any medical college from graduating students in less than four years from the date of their admission, unless the judg-

ment of the faculty distinguishes students for promotion in less time.

Fourth—The law that permits the creation of colleges and the conferring of charters by an organized body of men should be repealed. The creation of new colleges should be by special act of the Legislature and upon a showing that the necessity of a new organization actually exists.

Fifth—No man, having failed in his own college, should be permitted to pursue the same studies without a certificate from the faculty that his failure proceeded from no moral incompetency.

Sixth—In the matter of creating post-graduate schools, the prohibition should not apply wherever an organization is founded upon newly ascertained scientific principles. My remedy aims, so far as it can, at the prevention of overproduction and the encouragement of incompetency, not at the suppression of opinion.

Gentlemen, \* \* \* upon you, therefore, as graduates of Cooper, will devolve the duty, not only to strike out, and profanely speaking, make yourselves successful; but the higher mission is before you to assist in restoring the high ideals and standards of your profession, to educate your people to a conviction that to be a physician means to be not only a successful man but a wise and good one, and to assist in disseminating those high principles of honor and integrity, which, deeply rooted in the convictions of society, will be its firmest safeguard against the evils complained of and will restore the ideals of your noble craft to all their proud beauty. Your lives are before you, and you yourselves will be the sculptors of your fortunes. See to it, I pray you, that your standards remain high. You will not only be the healers of men, but their teachers. Qualify your-



selves for such high duties. Let men understand that your skill and wisdom are not merchandise, but that you are servants of humanity. And, pursuing this ideal course, the reward will be the approbation of your foster mother. Science, glorying that her sons and daughters have not forsaken her to follow the idols after which so many have gone astray. And thus, ladies and gentlemen, permit me to bid you godspeed and to invoke heaven's blessing on your future lives and careers.

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**VALEDICTORY ADDRESS AT GRADUATING EXERCISES OF COOPER MEDICAL COLLEGE.**

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Class of 1899.

BY PROF. C. N. ELLINWOOD.

We welcome you to the ancient and modern, beneficent and exalted profession of medicine.

The healing art was founded in the highest aspirations of man for the relief of human suffering.

Ancient lore, the recorded experiences and discoveries of all the ages, the vast results obtained by modern methods and the crystallization of the accumulated truths of time are compassed in this our great profession.

On entering the portals, your Alma Mater would have you feel the noble and enobling inspirations which have characterized the good and great men, whose names have adorned the cherished pages of medical history.

The study of man as an organism—the most complex, the wondrously beautiful structures of his physical being as presented to us by the microscopist, and the marvelous adaptation of them to the conservation and correlation of energy, by which human life is manifested, commands the admiration of all

whose minds have been trained by progressive studies to comprehend them.

After this preliminary study, pathology has inducted you into explanations and portraitures of man's diseases and deformities, deviations from and interferences with the normal and harmonious workings of the human economy. Superadded to that you have followed, the ingenious methods of therapeutics, most potently planned and in these latter days most successfully executed for the restoration of the abnormal to the normal, for the arrest and elimination of disease, the abatement of suffering and the prolonging of human life. By progressive steps you have been enabled to grasp the difficult problems of disease and its remedy, and understand them, as only can be understood by those who have acquired the necessary knowledge of the normal constitution of man, and the prolonged studies and exercise of the powers of observation by which scientific or exact deductions are made.

This training of the mind and this education of the special senses, which has been continued under the guidance and with the admirable facilities of Cooper Medical College during the past four years, has developed in you, we hope, your greatest possibilities for honorable distinction in your vocation and usefulness in the community.

A mind so enriched by the comprehensive education which you have acquired, enabling you to contemplate with intelligence the laws of life and the reason of man's existence in his relation to matter and force, in the Divine order of creation, grants you endowments and capabilities worthy of our great profession. You are indeed fortunate in entering upon a medical career under such fortuitous conditions and opportunities as present themselves to-day.



The clearly printed pages are open to you of all that has been discovered in the art and science of Medicine in the past, which remain as demonstratable facts. False and faulty theories, as well as harmful practices, have been dropped out all along the way of past experiences; many schools and systems of practice, conceived in ignorance and formulated on error, have been found unfit to survive and died out as tares by the wayside, while, on the other hand, there are no lost arts in medicine. All that which is good and true, in all that which has ever been known, remains today, an open book of knowledge to which you all have access and is your opportunity.

The great centers of learning throughout the world and the great laboratories of science and thought and discovery are now so intimately associated with each other by rapid communication and international fraternization, that facts and discoveries are being applied and perfected, additions made and crucial experiments and deductions determined by such a vast army of skilled observers, under such diverse circumstances that progress in science is advancing with an impetus unknown in the history of the world. And this is your opportunity; you are now entering this rapid flowing current of progress matured and capable, we believe, to maintain honorable positions in the ever-flowing stream of advancement, and we hope that not one of you may be caught out of the current of success, lodged by the wayside in any whirlpool of incapacity, laxity of honest purpose, disloyalty to professional ethics or other misfortune. You have had many and exceptional advantages during your four years of pupilage. You have had able and zealous corps of teachers who have conscientiously labored for your advancement.

You have been aided by complete laboratories in chemistry, anatomy, histology, physiology and pathology, and also the large museum and medical library of the College. You have had rare advantages of clinical instruction in the large and varied college and hospital clinics, and, in addition, you have had the extraordinary advantage of an annual course of instruction given by one of the most eminent teachers, selected yearly from all the great schools of medicine throughout the world. We look with pride and gratitude as we read the names of the four distinguished professors on the memorial tablet, who have so ably instructed us during the past four years. These learned teachers have come here with a world-wide fame in their respective departments of medicine, and with a year's time of preparation for this special course, and coming here for this sole purpose, teacher and pupil come into much closer relations of sympathy and personal influence than would be possible to any of us were we to seek it at their respective schools.

This supplemental course of instruction is an opportunity enjoyed only by Cooper Medical College. No other colleges in this country or in Europe has reached this admirable feature, and it is accomplished only by the wisdom and personal expense and broad-minded liberality of your eminent teacher and illustrious friend, Professor Lane, the life-long worker for the building up of the medical profession.

It is earnestly hoped that your interest in and association with Cooper College and Lane Hospital may continue throughout your whole career. The advantages of the College laboratories, the museum, library and clinics, also the Lane course of medical lectures are



freely open to you in all the future, your great opportunity.

To the Public: I would say a word of commendation of these last accessions to our ranks. You need have no fears of them.

Year after year you are expressing astonishment that the world is large enough to hold so many young doctors as are being graduated from the schools, and yet the supply is not equal to the demand.

We read of the times and crude civilization of the past when human life was so cheap and health was so little cared for that the healing art was relegated to priests and barbers, as their auxiliary work to be practiced when they had nothing more important to do. But now how changed. Life and health have come to be regarded as the most precious factors in our existence, and the healing art commands the devoted service of many of the greatest minds developed in these modern times, and certainly the exclusive occupation of a larger corps of workers than in all the other liberal professions combined. As knowledge grows among the people, medical advice and guidance comes to be a constantly increasing necessity and doctors of all sorts are demanded; doctors for the stomach, doctors for the eyes and ears, doctors for the nerves, doctors for the teeth, doctors for women especially, and others for children, surgeons and physicians and many of them for the army and navy, and yet there is room for more, including all the multitudinous "pathies" which human ingenuity and sophistry can devise.

Notwithstanding this apparently adequate supply of doctors, regular and irregular, yet the demand is still unsatisfied, if we may judge by the vast numbers of people, who are exhausting their

energies and shortening their lives doctoring themselves.

The public should know something in particular about Cooper Medical College, its uses and its aims. Founded forty-one years ago by the grace of God, and for the love of man, this pioneer medical school was established on the Pacific Coast. Its founders and their successors have labored earnestly and well in building up from a small beginning an institution which takes front rank with the best colleges of the land. Its numerous alumni, now numbering many hundred, have found a hearty welcome and merited preferment in the respective communities where they have made their abodes.

Cooper Medical College and its Lane Hospital gives medical relief to many thousands of the afflicted poor of the city and many human lives in jeopardy have been humanely treated and saved. The opportunity so presented has been used in instructing the students that they may go and do likewise. The result of this education is shown in the fact that the medical profession does more for humanity's sake, makes more personal sacrifices, without fee or hope of reward, than any other people in the community.

Cooper College has no capital stock, gains no money for the enrichment of anyone. It is free and independent of all political entanglements and financial enterprises. Its sole and undivided purpose is the cultivation of medical science, medical truths and the diffusion of that knowledge which relieves human suffering and aids man to attain his highest capabilities. Cooper College is beneficent in good work, though not a charity. The pupils pay the cost of their tuition and go forth with the manly satisfaction of freedom of indebtedness to the State or to any charity for their pro-



fessional education. Cooper Medical College commands the confidence and respect of the medical profession, and merits the highest consideration of the municipality of San Francisco. It pays to the county and State its own taxes and further attracts to the city a very considerable addition to the city's growth and revenues. Finally, if Cooper Medical College merits rewards at all commensurate with its uses and exalted aspirations, it will be perpetuated through all time.

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**RESECTION OF THE RECTUM AND  
BLADDER—COLOSTOMY—CURE OF  
ARTIFICIAL ANUS—RECOVERY—DEMONSTRATION  
OF PATIENT.**

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BY CHARLES G. LEVISON, M. D., ACTING  
SURGEON TO THE SAN FRANCISCO  
POLYCLINIC, VISITING PHYSICIAN TO  
THE MOUNT ZION HOSPITAL, ETC.

Read before the San Francisco County Medical Society.

The following case was recently operated upon in the service of the San Francisco Polyclinic, at the City and County Hospital.

L. B., age 65, male, children healthy, denies specific history; has always been in good health until 2½ years ago, when he fell into a cellar, striking upon the coccyx, sustaining a Colles' fracture of the right arm. At this time his bladder was distended. Upon regaining consciousness he experienced severe pain in his back, which persisted for three months, during which time his bowels did not act naturally, requiring the constant use of cathartics. He applied to me complaining of great difficulty in defecation together with loss of blood when his bowels moved. He had lost no appreciable weight nor did he complain of any bladder symptoms. Examination revealed a

broken down indurated growth, bleeding easily when handled and occluding the lumen of the rectum about two inches above the sphincter.

Clinical Diagnosis: carcinoma of rectum.

On July 25, 1898, the patient was operated upon for a left iliac colostomy, and the gut sewed to the peritoneum with catgut sutures, the spur being formed by a gauze strip pushed through the mesocolon, this being preliminary to the operation upon the rectum. After three days the colon was opened with a "Paquelin" which revealed a spur completely diverting the fecal current. Temperature never above 100 degrees. On August 3d after the rectum had been thoroughly disinfected with peroxide of hydrogen, through the artificial anus, the pelvis was elevated on a sand pillow placed under the abdomen, and a transverse incision together with the parasacral incision of "Rydygier" made, the lower end of the sacrum severed with a chain saw and the flap turned downwards and to the right. The object of this elevation of the pelvis is to facilitate operating as well as to diminish hemorrhage. The peritoneum was at once incised, and the growth found situated 1½ inches from the anus and extending about two inches up the rectum, involving its entire anterior wall. After the intestine was freed and the rectum severed above the growth, the lower end of the gut (about 5 inches) including the base and neck of the bladder the prostate, sphincter and anus, all of which were involved, were removed by working from above downwards, thereby performing a perineo-sacral operation. The upper end of the gut was attached by sutures to the skin beneath the sacrum, and the bladder closed with sutures. Recovery was uneventful, excepting that the bladder



sutures did not hold, a not unexpected result, as the entire base of the bladder had been removed. Subsequently the artificial anus was repaired as follows: after thorough disinfection of the gut through the artificial anus with hydrogen dioxide from above and below, it was dissected from the peritoneum to which it had become firmly attached. The opening in the gut being too large to close by suture, it was decided to reset the intestine, which was done, and the anastomosis completed by means of a Murphy button. Recovery was uneventful. The microscopical diagnosis of adenocarcinoma was made by Dr. P. W. Nathan, and a section of the removed prostate, which revealed cancerous infiltration, was demonstrated before the society.

The operation of excision of the rectum for malignant disease is now recognized as justifiable by almost all authorities, but opinions regarding the indications and contra-indications for a preliminary colostomy are widely divergent. The mortality of excision of the rectum varies according to different authorities, the general mortality being difficult to arrive at, for there will always remain a number of unpublished failures, which if published would alter statistics materially.

Ball (*Dis. Rect. & Anus* 2d ed. 364) has collected 175 cases with a mortality of 16.5 per cent. Hohenegg (*Wien. Med. Wochens.* 1897) reports 88 of his operated cases with a mortality of 10 per cent. Kraske's latest statistics (*Sammlung Klin. Vorträge*, 1897) as well as Koenig's give a mortality of 10 per cent, but the consensus of opinion amongst men skilled in rectal surgery, as Czerny, Quenu and Kocher being, that the general mortality is never less than 20 per cent. In Finet's thesis there are 375 cases

collected with 76 deaths, 42 from infection, 16 from collapse, 3 from congestion of the lungs, 11 through some unknown cause, but in this thesis the feeling is expressed that many cases of so-called collapse within the first 36 hours are due to a hyperacute sepsis. Quenu and Hartman claim that fully 80 per cent of all fatal cases are due to some form of sepsis.

The duration of life is a factor having a very important bearing upon the character of the operation to be followed out. In many cases the results have been excellent. There are firstly the well known cases of Volkman, who claimed three perfect cures, as well as cases which did not recur until 5 and 6 years after the operation. Esmarch has kept patients under observation where the entire rectum was removed and all were in perfect health, 3 4, 5, 6, 8 and 11 years, respectively, after the operation. Czerny reports 99 cases of radical operation, 21 of his patients being still alive after two years, 15 after 3 years, 13 after 4 years, 8 after 5 years and in four cases there had been no recurrence 6 years and 9 months, 8 years and 9 months, 11½ years and 13 years and 9 months respectively after operation. In Finet's thesis are reported Kocher and Arndt's cases, where there was no recurrence after 16½ years, 16 years and 2 months, 14 years, 10 years, 8 years, 6 years and 5 months, 5 years and 10 months and 4 years. Ball (*Dis. Rect.* 2d edit. 294) has had one patient alive and well 9 years and another 6 years after operation. Cripps (*Dis. Rect. and Anus* 422) has had one case free from recurrence, 12 years, two 6 years, one 5 years, two 4 years and one 3 years after operation. The foregoing statistics readily demonstrating that rectal cancer can be cured.



The character of the operation is next to be considered. Whether a preliminary colostomy or an excision of the rectum without any preliminary operation is to be preferred are questions which must be carefully considered by the operator. The average life after excision is about two years, and after colostomy performed for inoperable cancer, about eighteen months. Whether the average individual would be more comfortable with an iliac anus and an intact sphincter, or without his sphincter where a sacral operation has been made, is a question which still remains unanswered, there being a wide divergence of opinion relative to the preliminary colostomy. Jacobson (*Operative Surgery*) speaks strongly against the preliminary colostomy, stating that it wastes valuable time, entailing two operations upon a patient, too often of poor vitality and power to repair, and further that the results of excision of the rectum, especially those of Cripps and Allingham prove that the preliminary colostomy is not necessary.

Quenu and Hartman in their paper presented to the French Congress of Surgery held October 20, 1897, consider the preliminary colostomy an indispensable operation. Chaput, Routier, Reclus and Tuffier (*loc. cit.*) are all in favor of the preliminary operation. Pilcher in his article on "Surgery of the Alimentary Canal" (*Dennis Surgery*) states that a preliminary colostomy is desirable in all cases and imperative where obstructive and ulcerative symptoms are marked. Gerster, Kammerer and Schede recommend preliminary colostomy (*Anal Surgery* 495, 1895). Koenig in his "Surgery" relates a case of inoperable cancer of the rectum where a colostomy had been made and which enabled the patient to live in comfort for five years. Matthews in his "Diseases of the Rec-

tum" claims that colostomy is an unwarranted operation, excepting under certain conditions not prolonging life nor relieving pain, but that it only exaggerates the patient's suffering. Kraske (*Sammlung Klin. Vorträge*, 1897) is also opposed to the preliminary colostomy. By the foregoing it will be seen how divergent the opinions are, relative to this operation.

The next factor to be considered is the form of colostomy most acceptable to the patient, regarding which views vary materially. Sir Thos. Bryant in his Bradshaw lectures and Matthews both advocate lumbar colostomy, claiming decided advantage over the iliac colostomy, their reasons being: firstly, that the anus is easier controlled, not requiring the shifting of the pad when the patient changes position, as in the case of the iliac anus; secondly, that there is no prolapse of the bowel, which almost always occurs with the iliac anus, even though the colon has been pulled down at the time of operating and the mesentery rendered tense; thirdly, that the operation is extra peritoneal. On the other hand, the iliac colostomy is now recognized as the operation of election; firstly, having the advantage of ease with which the colon is reached; (Cripps (*loc. cit.*) claims that the colon at times is quite difficult to find;) secondly, that there is less mutilation of the deeper tissues predisposing to infection, and lastly, that the position of the anus is more convenient for the patient. The consensus of opinion being, that lumbar colostomy is only indicated in grave cases, necessitating the immediate opening of a distended colon. The next question to be considered is the degree of comfort the patient will derive from the operation, which implies, the degree of sphincteric action retained. If a classical resection has been made, and



the ends of the gut brought together, there will remain absolute sphincteric control, but if the sphincter has been removed, the amount of control will depend upon the contraction which subsequently takes place, this being so great at times as to require treatment by dilatation. In order to overcome the resulting fecal incontinence, Gersuny (*Centr. fur Chir.* V. 1893) advocates twisting the upper end of the rectum if long enough and fixing this twisted end to the skin by sutures. This procedure is performed by grasping the end of the gut with catch forceps and twisting it around its long axis until considerable resistance is experienced in introducing the finger into the bowel. He has treated two cases in this way. Ball (*loc. cit. supra*) has also used this method in one case with good result. Gerster (*Annals of Surgery*, Oct. 1895) has published two cases in which he used this method successfully and speaks highly of it. Another means of remedying this condition is suggested by Witzel (*Center f. Chir.* 40, 1894) who reports six cases treated successfully by the following method: a short incision having been made a little above the free margin of the gluteus maximus, the muscle is perforated with a blunt instrument and the rectal stump drawn through this opening, after which the stump is attached to the margin of the opening by sutures.

It might be well to mention the proper application of the terms used in rectal operations. Koenig in his "Surgery" speaks of "excision" when the gut ends are brought together, the sphincter remaining intact, "extirpation" when the peritoneal cavity has been opened, and "amputation" when both the rectum and sphincter are removed without opening the peritoneal cavity. The terms "fecal fistula" and "artificial anus" are

often misused. The "artificial anus" is an opening in the abdominal wall as well as in the gut, through which the fecal current is completely diverted by a spur, formed by a kink in the intestine. While the term "fecal fistula" is applied to an opening in the abdominal wall permitting the escape of some fecal matter, but not completely diverting the fecal current, there being no spur.

Before considering the various rectal operations it would be well to describe the peritoneal reflection in its relation to the rectum, this being a most important element in the surgery of this region. Allingham (*Inter. Encyl. of Surg.* Vol. VI) states that in the female the peritoneum dips down to within 3 inches of the anus, while in the male  $3\frac{1}{2}$  to 4 inches of the rectum are uncovered by peritoneum. This implies that in the male about  $3\frac{1}{2}$  inches and 3 inches in the female can be extirpated without entering the peritoneal cavity.

In the operation for iliac colostomy, the incisions differ according to different authorities. Howard Kelly (*Oper. Gynecol.* Vol. II), Koenig and Jacobson advocate an incision  $2\frac{1}{2}$  inches long made  $1\frac{1}{2}$  inches above and parallel to Poupart's ligament. Pilcher (*Dennis' Surgery*, Vol. IV) recommends an incision about  $1\frac{1}{2}$  inches from the anterior spine, having its mid-point upon a line drawn from the spine to the umbilicus. Here arise two points relative to the disadvantages of the iliac operation namely: prolapse and size of the incision. Cripps (*Complications Arising in Inguinal Colostomy*), *British Medical Jour.* Oct. 15, 1895) finds that by making his incision somewhat higher than in his earlier cases (he now makes his incision nearly as high as the level of the umbilicus), there is less tendency to prolapse. Kraske (*Samm. Klin. Vort.*, 1897) opens the



transverse colon, which diminishes the tendency to prolapse, and also has the advantage of not shortening the descending colon, which when shortened necessarily interferes with the subsequent removal of the rectum. Secondly, the opening should be as small as possible, for the freer the incision, the weaker the abdominal wall already weak here, making it more certain to result in a large prolapse. After the abdomen has been opened, the colon usually presents. Occasionally it does not present, when considerable difficulty is experienced in recognizing and locating the same, although Matthews in his book says that it would be as farcical to ligate the prostate for a pile as it would be to open any other gut for the colon. When malignant disease is present there is frequently an atrophy of the longitudinal muscular bands and the epiploes, both of which are the land marks in recognizing the colon. Cripps (*loc. cit. supr.*) quotes a case in which he could not recognize the bowel until water was injected into it, when a part of the bowel entirely overlooked, became filled with water and presented in the wound. Pennington (*Amer. Med. Assoc.* II 773, 1893) failing to find the sigmoid, water was injected into the rectum when it was observed to pass in the direction of the right iliac fossa. The incision in left side was closed and another made in the right side, when the sigmoid was readily found. In cases where the intestine is not easily found, Cripps states that the colon will almost always be found nearer the median line of the abdomen than where the operator has been searching. When the bowel has been found, it is important, in order to prevent prolapse, to draw out as much of the colon as will readily come down, or in other words, until the meso-colon becomes tense,

passing it in again at the lower angle of the wound.

Excision of the rectum is performed for the following conditions: malignant disease, aggravated fistula, or stricture subsequent to ulceration either specific or dysenteric. Under excision of the rectum, the operations following Jacobson's classifications will be considered. I, excision by the perineal route; II, by the sacral route; III, combination of perineal and sacral routes; IV, excision by the vagina; V, abdominal section. In cases involving the lower 3 inches of the gut the operation is performed with the patient in the exaggerated lithotomy position, the incision being made into each ischio-rectal fossa and continued to the coccyx. The sacral operation is indicated where either the upper or middle third of the rectum is involved, the removal of which was made possible by the discovery of Kraske in 1885 (at that time Volkman's assistant in Halle) that the sacrum could be removed up to the third sacral foramen without impairing the functions of either the rectum or bladder. Prior to this time, Kocher had published a method called by him, his long posterior incision, which included an excision of the coccyx; in this operation of Kraske after the soft parts have been divided in the middle line, by a vertical incision, extending from the middle of the sacrum to the anus, and the coccyx excised, the left sacro-sciatic ligament is divided and the left margin of the sacrum up to the third foramen chiselled off. The removal of more of the sacrum has been exhaustively investigated by many operators, notably Hohenegg (*Wien. Klin. Woch.*, 1889, 20-30), Bardenheuer (*Volk. Klin. Vorträge* 2 98), Levy (*Centr. f. Chir.* 13, 1889), Rydygier (*Centr. f. Chir.* 1, 1893) and none excepting Rose go higher than the third foramen. Any



division of bone higher than the plane of the third foramen is attended with the risk of a permanent vesical paralysis. Various osteoplastic operations have been devised, two of which will be mentioned, viz: The osteoplastic operation of Rehn and Rydygier (*loc. cit.*) is made as follows: A long parasacral oblique incision is made through the soft parts along the left border of the sacrum and coccyx nearly to the anus, then a transverse incision is made across and about two fingers breadth above the middle of the sacrum, which is then divided with a chain saw or chisel at the proper level and the bone flap turned to the right. This method is well spoken of by Gerster and Kammerer.

The osteoplastic operation of Levy (*loc. cit.*) is made with an inverted letter U incision, the horizontal arm of the U crossing the middle of the sacrum and the two vertical arms going down on each side of the sacrum. The bone is then divided with a chain saw and the flap turned down. All of these operations give ample room to remove any part of the rectum and although hemorrhage in many of the cases is quite profuse, it is not advisable to waste much time in hemostasis, as hot water usually controls the bleeding in this region very satisfactorily. As soon as the growth has been palpated, the peritoneum opened, the finger is introduced into the peritoneal cavity and the rectum hooked up, but this is not possible until the peritoneum, which acts as a lateral ligament, is incised. If the dissection is carried on close to the sacrum, there is little danger of interfering with the blood supply of the rectum, this being very important as any disturbance with the nutrition of the gut would interfere with success of the operation. If a resection of gut with intact sphincter is

decided upon, the growth is removed between clamps and the ends of the intestine brought together with either a Murphy button or sutures, if the sphincter is involved as in the case reported, the upper end must be brought down and sutured to the skin under the sacrum.

There have been various invagination methods devised notably Maunsell's, which we have not time to describe. The rectum has also been removed through the vagina with satisfactory results.

Quenu and Hartman (*loc. cit.*) operate through the abdomen and perineum at one sitting, by placing the patient in the inclined position, liberating the recto-colon through a lateral abdominal incision. The gut is then cut, a colic end of the intestine being sutured in the iliac wound and the rectum, the upper end of which is closed by suture, is removed by the perineal route treating the closed rectum as a simple cyst. This method is in the opinion of the writer an ideal method of dealing with growths involving the lower end of the intestinal tube almost doing away with sepsis.

606 Sutter St.

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### THE RELATION OF THE RECUPERATIVE POWERS OF NATURE TO MEDICAL PRACTICE.

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BY G. L. SIMMONS, M. D., SACRAMENTO.

Read before the California Northern District Medical Society.

In consideration of the subject, I desire to begin by briefly referring to some historical facts, which have come under my observation as a student and practitioner during the last half century. About the beginning of this period a reaction from the indiscriminate use of drugs in the treatment of disease took place. Up to that time the average physician had the most implicit confidence



in active remedies, or what was then called heroic medication, and teachers and text-books united in the opinion that for every deviation from a healthy standard in the human system it was necessary to prescribe a drug remedy. I believe it will be admitted that one of the chief causes for an abandonment of a reliance on a purely drug treatment in all cases of disease was the circulation of works on the recuperative powers of nature by some of the oldest and wisest members of the medical profession in America and England. The positions taken by these authors and the truths revealed by them were generally accepted with enthusiasm and their good effect soon became evident. In those works the distinguished physicians contended that many cases of disease were really cured by a force or power inherent in each individual and that no amount of drug influence was necessary in such cases to promote the action of natural functions, and which might interfere with those processes, which invariably end in a restoration to health.

John Bigelow, of Harvard, in his work on this subject, divided diseased conditions into three classes, (1) self-limited diseases, or "those which receive limit from their own nature and not from foreign influences; those which after they have obtained a foothold in the system cannot be eradicated or abridged by art; but to which there is due a certain succession of processes to be completed in a certain time, which time and process may vary with the condition of the patient and may end in death or recovery, but are not known to be shortened by medical treatment." (2) Diseases of uncertain duration, incurable diseases.

This change of practice, brought about, as I believe, under the influence already mentioned, was also aided by

the fact that at about the same period there came into general publicity in the United States three comparatively new plans of medical practice called botanic, hydropathic, and homeopathic systems.

The first of these insisted that no mineral medication should be allowed and that every disease had its best and proper remedy in the vegetable world. Many poorly educated men assumed the part of physicians under this title and no doubt cases of diseases were cured by this botanic practice.

The hydropathists appeared most enthusiastic over the use of cold water, particularly in all fevers and in most inflammatory conditions. There can be no doubt of the success of this plan of treatment in some cases, and viewed in the light of modern experiences, with the Brand method or with the application of cold in the high temperatures of typhoid fever, we must admit the hydropathic system offered some advantages over a reliance upon purely drug medication.

The last of these so-called systems was originated by Hahnemann in Germany, who according to one of his followers threw out the banner of "the law of similars," the single remedy and the minimum dose. Probably one of the best and latest expositions of the character of the medical agents used by the homeopathists is that written by Mrs. Eddy, the founder of what is called Christian Science, and who for years was a devotee of the doctrine of Hahnemann. She says: "In homeopathy the highest attenuations of medicine have not an iota of the drug left in them and the lower attenuations have so little that a vial full of the pellets are swallowed without harm and without appreciable effort, whereas the homeopathist administers half a dozen of these same glob-



ules and tells you and you believe him that therewith he heals the sick."

To introduce these variable medical practices, the first step appeared to be a detraction of the regular system of practice and the continued use of a title, invented by Hahnemann, which conveyed to the average mind an impression, untrue and erroneous, that the teachings of the medical schools followed a "pathy."

Every charlatan appeared to unite with the representatives of these irregular systems in the use of the Hahnemannic term "allopathy" and so persistently was this title used without contradiction that many people still believe that there is an allopathic school of medical practice, which is bound to confine its teachings upon lines laid down by the fathers of medicine. I believe no associated effort has ever been made to correct such a false impression, or to show that regular practice has always been changing and ready at all times to adopt any measures, which time and experience proved could be useful in the cure or alleviation of disease.

Emboldened by apparent success these irregular practitioners challenged a comparison of methods and results, and it came to be determined both in private and hospital practice that in those diseases, which may be called self-limited, the percentage of recoveries was about the same under any or no medical treatment. Taking a case of small-pox, or scarlatina, or measles, or whooping cough, or any of the list of diseases, which have a regular course, and the administration of drugs by the usual attendant or the vegetable medicines of the eclectic, or the practice of mental therapeutics, or the hoodoos of the black man, or the similars of the homeopaths, or the cold water cure, all are alike

inoperative in effecting a cure until nature has by her own perfect process completed the process of elimination of the pathognomonic germs.

Such facts as these prove conclusively one thing, and that is, we are not to underrate the powers of Nature, but to admit that there is a recuperative principle in the human body to repair an injury oftentimes in spite of medical treatment. So very important is the work of spontaneous restoration, as quoted by Bigelow from Sir Gilbert Blanc, that without it the human species long ago would have become extinct. This powerful agency often called the "*Vis Medicatrix Naturæ*" is present in every organ and every animal tissue. It is the principle of life itself, which enables the body not only to repair a traumatic injury but to resist the encroachment of disease and to add strength to the cells of animal life.

For quite a long period medical men apparently yielded to these stated views upon the power of nature. Medication became less and less heroic, and even in standard authorities the treatment of so important a disease as typhoid fever seemed passive and far removed from heroic drugging. More attention however was given to the surroundings of the patient, to pure and proper food and drink, bathing and trained nursing.

A later swing of the pendulum, and now in certain localities an amount of drugging is insisted upon in the treatment of typhoid, which, in comparison with that of the first half of the present century, far exceeds it both in the use of active agents and in the variety of remedies. In the language of Professor Flint, "the profession now appears to be possessed of a pharmaco-mania or form of aberration, which like affects patients and physicians."

One of the reasons for this relapse into



poly-pharmacy may be traced to the influence of the flood of medical literature, issued in favor of special remedies by manufacturing chemists in Europe and America, which remedies are made by secret processes and put up in peculiar forms. Names unknown to any pharmacopeia are copyrighted and with the boldest pretensions agents of these manufacturers visit practising physicians and give advice in relation to the uses of these special remedies. Free samples are tendered, and an examination of the accompanying literature will show that the pamphlets are written not alone for the eye of the doctor but in such a style that the comprehension of the invalid is sufficient to penetrate the film of honest statement and into the aim of the author to get his opinions in circulation among the laity. The large number of these new preparations, each claiming superior qualities, renders it almost impossible to remember their names or chemical composition.

Especially is this the case with the coal tar derivatives which it is claimed inhibit the development of pathogenic germs and which undoubtedly lead in the work of establishing a new code of pharmaceutical morals. It is said that judicious medical advertising of these products has already brought fortunes to their manufacturers. In looking over the recent literature upon one of these compositions I have been struck with the nature of the argument, used by the compiler to impress physicians with the value of the new drug in case of typhoid fever. For instance, one of his first attacks is upon the "Brand" method so often used successfully in that disease. He says: "The cold bath is a refined cruelty, increasing the tendency to hemorrhage, causing chilliness and cyanosis, rheumatoid pains in the limbs, stupor

and delirium, while the new compound accomplishes the desired result of reducing temperature, pleasantly, surely, promptly and safely. He further states that the proportion of relapses and the number of deaths are both actually increased under the use of cold, while his remedy has no such results."

But it is not alone in the use of coal tar products that we are solicited to give opinion for advertising purposes. Mental therapeutics and organopathy claim recognition and many of the tissues of animal life are laid under tribute for new preparations to work upon the credulity of patients and physicians. This class of remedies may at least appeal to antiquity for recommendation. In the Chinese medical catalogue arranged by that government for the "World's Fair," we find a long list of remedial agents, which have been in use in the "Flowery Kingdom" for hundreds of years. Among them are powdered testicles of the deer as a tonic for the sexual apparatus; the lining membrane of the chicken's gizzard for dyspepsia with a refinement of directions over our own in the case of ingluvin, i. e., the male bird should always be used for female patients, while the female fowl should always be ordered for male sufferers; the blood of the human placenta for consumption and bear's gall for all affections of the liver. With these varied preparations added to a pharmacopeia, already overcrowded, is it not time for us to consider the question of their practical value and to ask how far many of these agents have been given credit for beneficial effects, when the true cause lay in the powers of nature? Take the large number of remedies ordinarily prescribed in tubercular cases, are they in any sense curative and do we believe they have aided in any degree the defensive processes within the



affected organs? Alas! the mortality tables are against such assumption and while we have known for many years of spontaneous recoveries from tubercular invasions, there is a consensus of medical opinion that a specific treatment for this terrible disease is still in the period of hope. A generation ago, when early recognition was possible, these cases were sent in summer to the Sierras and in winter to the dry and sandy region of Arizona and New Mexico. In such localities with an open air life by day and night, with plenty of the healthiest animal food and the purest water, many invalids were relieved, and it is my judgment that such a course possesses the greatest advantages over the serum treatment or any form of drug medication. It is a plan where the kindly efforts of nature are aided by surroundings, which add strength to the system when the vital powers are weakened by incipient disease.

In conclusion let me ask, if it is not wise to realize that the world requires and asks for a definition of what is regular and rational medication. It is besieged by appeals from charlatans and numerous "pathies" for recognition. It hesitates not to discuss medical knowledge and its sympathies are often given to the marvelous and irregular, for want of information as to the true position of medical science, and what it can and what it cannot do for the cure of the sick. Time was when ignorance, superstition and folly were the only opponents, but now a large class of educated men and women declare that the cure of disease may safely be left to the influence of the mind over the body and its function, and that governments have no right to interfere with the employment of faith cure doctors, who make no pretense to a medical education. Has not

the growth of these and all other irregular methods been aided by a want of knowledge upon self limited disease, and what class can be aided by art, or as stated by Professor Jackson "by that recuperative power, which the All Wise has bestowed upon the human system?"

If we have over-estimated the value of drugs and in our daily work given credit to the idea that in all diseased conditions their administration holds a chief position, let us return to the faith of the wise physician, who said "the human body is endowed with a self recuperative power and this inherent power is the physician's main reliance." Our age is characterized by the hasty readiness of physicians to adopt new opinions and new plans of medical treatment; but observation and reflection do not often go hand in hand, and in consequence we fail to penetrate the secrets of a yet imperfect science or benefit the cause of rational medication. Let us hope that in no distant period the triumphs of medical practice may be free from empiricism, remembering the aphorism of Austin Flint, "that our science is astray, when it opposes, instead of co-operating with the indications of nature."

212 J Street.

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#### A STUDY OF CÆSAREAN SECTION.— FOUR CASES.

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BY W. S. THORNE, M. D., SAN FRANCISCO.

CASE I. Operator, Dr. Luke Robinson.

Mrs. B., primipara, age thirty, admitted to St. Mary's Hospital March, 1892, under the care of Drs. Robinson and Thorne. Patient in labor thirty hours. Has a flat rachitic pelvis, anteroposterior diameter much diminished by forward bulging of the sacral promitory. After the usual preparation the abdomen



was opened and the uterus exposed. The uterus was opened in situ by the median incision. The hemorrhage was very profuse as the incision encroached upon the placental site. The abdominal cavity was protected by pressing the parietal opening snugly against the sides of the uterus. The child was seized by the feet and readily extracted, the head not having engaged in the superior strait. The placenta was detached without difficulty, and the uterine cavity flushed with hot sterilized water, stimulating contraction and modifying the hemorrhage. The uterine edges were united by two sets of silk sutures, superficial and deep, and the abdomen closed in the usual way. The mother succumbed the second day to the combined result of hemorrhage and shock; the child, weighing seven pounds, survived. Contraction of the uterus was unsatisfactory, and from the first resisted all efforts to improve it.

CASE II. Operator, Dr. W. S. Thorne.

Mrs. A., age twenty-eight, native of Italy; primipara. Patient entered St. Mary's Hospital May 24, 1894, having been in labor four days and undergone a transportation of forty miles. Examination revealed a typical flat pelvis, the antero-posterior diameter of the superior strait one and one-half inches. The sacrum was crowded down into the pelvis. The amniotic sac had ruptured two days before. Operation was advised, and after etherization an incision was made in the median line from a point two inches above the symphysis pubis to within an inch of the ensiform cartilage. The uterus was drawn out, a rubber band wound about the neck, and the abdominal incision drawn snugly together by three sutures, which included the entire thickness of the abdominal parietes. The wound was covered with rubber sheeting, upon which were placed hot sterilized towels, on which the uterus was

allowed to rest. The uterus was opened by the long median incision. The bleeding was nil. The position of the child was as follows: Occiput in the right iliac fossa, the right arm filling the contracted superior strait. The placenta was at the normal site. The child was extracted by the feet, the cord tied, the placenta detached and the uterine cavity cleansed by hot sterilized water. The uterine wound was closed by deep silk sutures half an inch apart, which included all the tissues except the mucosa. Between these were placed superficial sutures, which closely approximated the peritoneal margins. The abdomen was closed in the usual manner. The patient was freely stimulated, and hypodermics of ergotine administered. She had no unfavorable symptoms; the temperature never rose above 100°, and the bowels performed their functions from the second day. The mother left the hospital the beginning of the fifth week in perfect condition with a healthy ten-pound child.

CASE III. Operator, Dr. C. C. Mohun.

Mrs. G., age twenty-three years; primipara. Two days before the oncoming of labor. Measurements of the pelvis by a distinguished gynecologist were said to be normal. I was called in consultation after the patient had been in labor twenty hours. The head was at the superior strait, occiput to the right ilium. The antero-posterior diam. of the pelvis was less than an inch and a half by reason of an exostosis of the sacral promitory. Delivery *per vias naturales* was impossible and the patient was removed to St. Mary's Hospital, where I assisted Dr. Mohun in a Cæsarean section. The median incision was made, the uterus lifted out, the abdomen closed and the cavity protected by hot sterilized towels. The uterus was opened in the median line and a dead child extracted. The placenta removed and the uterus cleansed and stimulated to contraction by hot sterilized water.



Superficial and deep silk sutures were employed, as in the former case, to close the uterine opening, and the abdomen closed. Bleeding was prevented by the rubber ligature. The patient was much exhausted, rallied with difficulty, and died on the fourth day of septicemia. In this case contraction of the uterus was very unsatisfactory from the first.

CASE IV. Operator, Dr. W. S. Thorne.

Mrs. F., age twenty-two years; primipara; last menstruation April 26th; confinement due January 10th. Patient sent to me by Dr. W. S. Taylor of Livermore, who had diagnosed a deformed pelvis. Entered the Waldeck Sanatorium January 4, 1898. Pelvimeter shows measurements of pelvis as follows: Antr. superior spines,  $20\frac{1}{2}$ ; iliac crests, 21; Baudelocque, 19; pelvis chyphotic. At six years of age she began to have enlarged joints and at the present time she has partial ankylosis of both knees; enlargement and stiffness of the finger joints; joints of toes normal. There is some limitation of motion of the hip joints; spine chyphotic in the lumbar region; abduction of the thighs much limited. Examination per vaginum shows a long, narrow sacrum with the promitory high up and out of reach. Irregular bony prominences on the lateral walls of the pelvic basin; the pelvic arch is narrow, and the transverse diameter between the tuber ischii much shortened. During the night of January 2d she had pains, which were relieved by morphia, administered hypodermically. On the morning of the 3d the pains had ceased and the os uteri was found to be dilated to the extent of an inch or more. After the usual preparation the abdomen was opened, the uterus lifted out, the abdomen closed by several sutures and covered with hot sterilized towels; the neck encircled by an elastic ligature, and the uterus opened by the median incision. A living, medium-sized child was extracted; the placenta removed, and the operation completed by the removal of the uterus; extra-peritoneal treatment of the stump, and fixation with the Koerbele serre noeud. There was no hemorrhage and no shock following the operation. The temperature rose the second

day to  $101^{\circ}$ , gradually fell to normal within the next three days, and remained so during an uneventful convalescence. One month from the operation the cicatrix was perfect, and the patient left for home with a  $7\frac{3}{4}$ -pound infant, during the fifth week.

#### COMMENTS.

Case I. Presents an example of death to the mother from hemorrhage, the uterine incision having been made unfortunately through the placental site, and no adequate provision having been made to arrest the hemorrhage attendant upon this always possible accident. It is no easy matter to locate in a gravid uterus the exact boundaries of the placenta. It can hardly be done by palpation and inspection; auscultation was not employed, and might be found useful to determine this point. Objections have been urged to the use of the elastic ligature about the uterine neck to control hemorrhage in Cæsarean section because of dangerous traumatism to the peritoneum. I am convinced that this danger has been greatly exaggerated. The peritoneum is a highly vitalized organ and in abdominal operations we daily wound, bruise and compress portions of the peritoneum with apparent immunity of consequences. The elastic ligature if properly applied, is, in my opinion, harmless, and eliminates an ever-present danger to an incision of the gravid uterus. Exhaustion from prolonged labor and hemorrhage contributed doubtless to the loss of contractile power of the uterine muscles, complicating this case.

Case II. This woman presents an example of endurance that tests our credulity. She was said to have been in labor four days and had been brought from the mountains in a wagon thirty miles to San Rafael, and thence to this city, during labor. The technique of this operation differed from the first in lifting the uterus from the abdomen before incision, and the use of the elastic ligature to control hemorrhage. Authors disagree as to the advisability of this step in Cæsarean section, alleging greater shock from handling and exposure of the uterine body. I am persuaded that the



elevation of the uterus, and the accurate closure of and protection to the abdominal cavity, are advantages that greatly outweigh the danger of increased shock. To these advantages may be added the perfect control of hemorrhage, and the increased facilities afforded the operator in extraction of the child, detachment of the placenta, and the accurate and satisfactory placing of sutures; a most delicate and important step of the operation. Exposure of the uterus need not exceed five minutes. After the extraction of the child and placenta it can be best handled during the remainder of the operation enveloped, save a small space anteriorly, in hot, sterilized towels. The application of heat and the pressure of the surrounding hands thus afforded, excites contraction of the uterus in a marked degree. During my absence abroad, and four months after this patient left the hospital, she applied to my late colleague Dr. Robinson, for a painful swelling in the lower fourth of the cicatrix which discharged a small amount of pus, but no suture was eliminated. For the following data I am indebted to the courtesy of Dr. Dudley Tait. The patient came under the care of Dr. Robinson at St. Mary's Hospital for the cure of the resulting fistula. She said the swelling previously referred to had gradually increased in size, and at times was quite painful. The fistula had discharged pus constantly. Menstruation had been regular since the operation, with the exception of two months. Last menstruation had occurred one month prior to consultation with Dr. Robinson. External palpation showed a very hard globular mass slightly to the left of the median cicatrix, adherent to the abdominal wall. An attempt was made to probe, and dilate the fistulous tract, but was unsuccessful. Everything, however, seemed to indicate that the fistula led to the subjacent mass. Attributing the mass and resulting fistula to the presence of a retained suture, Dr. Robinson made an incision in the lower half and slightly to the left of the median cicatrix. It revealed a most confusing condition of affairs, which, after investigation, proved to be as follows: The fundus of a normal

sized uterus was firmly adherent anteriorly to the abdominal wall. Laterally a mass the size of a hen's egg adhered to the fundus, and to the abdominal wall in front; this mass being composed of an atrophied ovary and a ruptured tubal pregnancy. As the uterus had been somewhat lacerated during the operation, it was decided to remove it, with the appendages. The patient subsequently died from the shock.

Case III. This confirms our belief in the tendency to septic development after repeated examinations, instrumental interferences, and the exhaustion of prolonged labor. The happiest results in future Cæsarean operations will follow, in my opinion, in those cases operated upon before the beginning of labor. Almost universally it has been held that the operation should not be performed until labor has begun, but before the escape of the liquor amnii. The physiological results in respect of uterine contraction, and the natural evolution of the various acts which complete parturition, are then said to be secured for the operation as for the natural delivery. On the other hand, such weighty authorities as Harris and Coe hold that the chances of success are greater by operating before the onset of labor, and in this opinion I heartily concur. It is based upon the fact that the uterus contracts just as well after operating and before labor as after labor has set in. We set our own time for a deliberate operation with perfect assistance and surroundings, and operate during daylight upon a patient thoroughly prepared. The condition of the patient rapidly deteriorates after labor has set in, uterine fiber becomes exhausted, repeated examinations and fruitless efforts at instrumentation all weigh against the patient, and favor the development of the septic state.

Case IV. A puerperal hysterectomy or a Porro operation modified by the extra-peritoneal treatment of the stump. The case happily illustrates the advantages of operation before labor; careful preparation; deliberation; perfect assistance and surroundings. The absence of shock, hemorrhage, and fever in this patient made her condition a little better than the average of



primipara after delivery per *vias naturales*. The fixation of the stump by the extra-peritoneal method may, in the light of present methods, excite comment and criticism. It is not the ideal method certainly, but in my opinion and experience it subserves an ideal purpose, namely, the greatest safety to the patient. If properly shut off by accurate stitching of the parietal peritoneum to the stump at the lower angle of the wound, and its constriction in this position by the *serre noeud*, no accident to the peritoneum has ever happened in my experience; nor have I ever seen, to the present moment, a death following a hysterectomy after this method. The momentous question of preserving or removing the uterus, relative to the safety of the mother, presents itself in every Cæsarean operation. The enormous fatality attending this operation arises chiefly from the gaping of the uterine wound, resulting from the natural shrinkage of the uterine fiber. In the process of involution the tissues shrink, the sutures become loosened and serve as seatons to convey septic material from the uterine cavity to the peritoneum. It will be held that this difficulty has, in a great measure, been overcome by the Sanger Leopold suture, which inverts a narrow margin of peritoneum on either side of the uterine incision. The success attending this important modification in the technique of Cæsarean section has reduced the mortality of the operation, until now it is regarded by many operators as the most favored of the two. Still we cannot rely upon such results. The condition of the uterus at such a time is one of unrest. The varying contraction and relaxation of the muscular fiber is unfavorable to primary union, and sutures, however skillfully placed, cannot be depended on to maintain exact coaptation of parts. A second more formidable obstacle is encountered in the difficulty of exciting contraction of the uterine muscle and maintaining it in a condition of safe contraction. It is not to be denied that in the hands of the abdominal surgeon, skilled in intraperitoneal technique, the conservative method of the Cæsarean operation may be safely left. But this is

an operation that from the very nature of things must frequently fall to the lot of those not so skilled; and the Porro operation and the extra-peritoneal treatment of the stump, presents at once, in my opinion, the easiest and safest method of procedure. Had I operated by the Porro method in Case II my patient would have been spared the catastrophe which followed four months later, and which cost her her life. It is my firm conviction that the dangers arising from the vicissitudes of an opened uterus, containing septic matter, depending upon a long line of fallible sutures, placed by hands however skilled, is a greater menace, as to sepsis, than the extra-peritoneal stump—of that uterus removed. I do not believe that the mere section of the uterine neck adds to the shock of a Cæsarean section. The highest attainment possible in this operation is the salvation of both mother and child, and that I believe to be the Porro operation modified by the extra-peritoneal treatment of the stump.

Gadson gives a mortality of eleven out of fifteen Cæsarean operations by the intraperitoneal method, which, though not final, is very suggestive. Under what conditions is the Cæsarean section absolute? Kelly in his classical work lays down the principle that section should be preferred to any other procedure when the true conjugate diameter is  $2\frac{5}{8}$  inches or less, or in a generally contracted pelvis and in a pelvis measuring  $1\frac{3}{4}$  inches in case the child is dead. In a pelvis whose conjugate diameter is  $2\frac{4}{5}$  inches, Kelly concludes the choice is between symphysiotomy and Cæsarean section, to which latter operation he gives preference. That the Cæsarean operation may be considered relative to symphysiotomy, high forceps and craniotomy is well shown in a case cited by Kelly upon which these several operations had been successively made. The subject had a flattened pelvis, measuring 7 centimeters— $2\frac{4}{5}$  inches. After reviewing the various operations, and the results of each, relative to mother and child, Kelly inclines to regard the Cæsarean section as preferable under like circumstances.



# Occidental Medical Times

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## THE COMMENCEMENT EXERCISES OF COOPER MEDICAL COLLEGE.

On the 22d of August amid the plaudits of admiring friends forty-four graduates were handed their diplomas and bid a hearty God speed in the struggle for fame and existence in the busy and hard worked world of medical life. The exercises were greatly enjoyed by an audience that crowded the hall to overflowing.

The loyal valedictory, full of warmth and promise for the future of these young men and women, was delivered by Professor C. N. Ellinwood.

The address of the occasion was made by Rabbi Jacob Voorsanger and commends itself very forcibly to the public, the legislatures, the faculties of our various schools and above all to the originators of newly proposed schools and those intending to enter upon the study or practice of medicine. It is a well considered and earnest appeal to those who have the interests of the community at heart and to those laboring for the advancement of education either as a medical study or as preliminary to such a vocation. His ringing words in behalf of higher ideals, higher and nobler aims in this and all professional work, his vehement protest against sordid commercialism and "licensed quackery" will, we have no doubt, long resound in the hearts of his audience and those, who leave the kind and fostering care of their Alma Mater. As a whole his deductions are very commendable but we cannot fully

concur in the opinion that preliminary education is the main and surest means, by which to raise the standard of medical education, for the simple reason that such education is of too variable a quality and quantity and has no uniform or definite rule by which its real worth may be ascertained. The degree of bachelor of arts or any certificate in letters is too easily and cheaply obtained and possesses too many of the objectionable features of the average medical degree. We are firmly convinced that the only way to equalize and definitely raise the standing and value of the medical diploma is through a national board of examiners appointed, upheld and freed from factions and temptations by our National Government.

## OPENING OF THE COLLEGE OF PHARMACY.

The California College of Pharmacy commenced its twenty-eighth annual session on Wednesday, August the 16th. As there had been no formal dedication of the new college last January, when they were taken possession of, the directors and faculty decided to invite the friends and benefactors of the college to attend this opening. Of necessity the exercises had to take place in the forenoon, and as the distance to the college from the down-town stores is considerable, it did not seem likely that many would take the trouble to go there at that time. Three hundred and fifty per-



sons, however, attended and seemed to greatly enjoy the reception.

At 10 o'clock the guests, faculty, directors and students assembled in the lecture hall, crowding it to the very doors. Later they were welcomed by G. E. Bacon, President of the college, who having been one of the first graduating class, was well fitted to give a short history of the early struggles and later development and prosperity of the college. After referring to the extension of the course of instruction and the redistribution of a portion of the work, he called upon Frank T. Green, Professor of chemistry and director of the chemical laboratories, who greeted the students and their friends in a short and happy address, in which he referred to the large amount of practical instruction now given by the college.

Dr. C. Hadley Carlson, associate professor of physiology, toxicology and urinalysis, was next called upon and responded in a short speech.

President Bacon then called upon the dean, W. M. Searby, professor of pharmacy and director of the pharmaceutical laboratories, who spoke on the topic, "Pharmacist Wanted; a Thoroughly Practical Man." He showed that while much practical knowledge could be acquired in a drug store without study, a pharmacist's education was not complete without a good foundation of theoretical knowledge. This, supplemented by well directed, practical work in a pharmaceutical laboratory, was needed to make a thoroughly practical pharmacist.

At the close of these exercises the guests were shown over the building, and after inspecting the laboratories, museum, etc., were invited to partake of a light lunch. There were many expressions of pleasure by those present at what they had seen.

The college is now in full operation, students and professors having entered upon their work with enthusiasm. There are about twenty more students this year than last.

## SOCIETY PROCEEDINGS.

### SAN FRANCISCO COUNTY MEDICAL SOCIETY.

August, 1899.

#### EXTRA-UTERINE PREGNANCY.

Dr. E. E. Kelly read a paper on "EXTRA-UTERINE PREGNANCY" and showed some specimens of cases.

Dr. J. Henry Barbat exhibited two specimens and spoke as follows:

"I have here some specimens which I removed recently. On account of the early diagnosis of the condition, they may be of interest.

"In the first case, the specimen has been rather spoiled on account of being soaked in blood. You can see the rupture in the tube, which was broken right across. The distal and proximal ends were normal. Upon opening the abdomen, the pelvic cavity was found filled with blood,—about a quart. The patient made a steady recovery. This fluid was removed and also the appendix.

"This specimen was removed at the beginning of last month. It shows down in the sac a little projection attached to the wall of the sac, and on examining with a glass, you can see the beginning of the fetus. I judge it was in about the second week.

"The diagnosis was based in both cases, on the subjective symptoms alone. The physical signs availed nothing. The patients had missed their menstruation and shortly afterwards had pains in the abdomen and hemorrhage. The pulse increased slightly and so did the temperature. The pain was sharp and lancinating, at first diffused, and finally localized on one side. This made me positive of the diagnosis.

"In this case, where the tube was ruptured, the patient passed small bits of membrane, which, on microscopic examination, revealed large, decidual cells. The most difficult thing is to make the diagnosis. After this there is only one thing to do. Remove the whole. Take the tube and the ovary out, if necessary. If the ovary is separated from the tube, it is just as well to leave it in. In making the diagnosis, if any membrane is passed, and extra-uterine pregnancy is suspected, the use of the curette will bring away a piece of the uterine mucosa for examination."



Dr. Strunsky:—"Dr. Kelly advised operation in all cases of ectopic pregnancy. I would like to ask Dr. Kelly if he deems operation advisable in the very early period, where we are positive that such condition exists. Out of a hundred cases, as the doctor has said, seventy-six recovered. If I remember correctly, in Thomas and Munde's Gynecology, out of forty-three cases of ectopic pregnancy, one died. The one that died was only due to rupture of the artery and not to rupture of the sac."

Dr. F. B. Carpenter:—"In confirming the diagnosis by use of the curette, as has been suggested, it is not always necessary to resort to the microscope for that purpose. The normal membrane has not the appearance of the decidua vera, which is curetted away and which is thick. One can really justify himself in doing the operation by the gross appearance of the decidua without the use of the microscope. There is but one course to pursue, the diagnosis having been made. All the past methods of postponing the operation are hazardous. The operation itself is practically devoid of danger, at least, as much so as any abdominal operation can be. In the first place, if the case is recent, you have a clean case to deal with. When you have commenced your operation, you very frequently verify it as soon as you have reached the peritoneum, which, before you open it, frequently is dark and sometimes even black, and you recognize blood below it."

"I am inclined to agree with Dr. Kelly that pelvic hematocoele is invariably due to extra-uterine pregnancy. Many other causes have been ascribed, but I think that so far literature agrees that it is due to fetation."

"I want to call attention to the little specimen shown by Dr. Barbat, as being one of the smallest that I have ever seen. This one is so small that it requires a glass to show conclusively that it is the beginning of a fetus."

Dr. Robertson:—"The subject of ectopic pregnancy has become so very much plainer during the last few years that it is making it easier of diagnosis. About a month ago, I was called in consultation with Dr. Bunker about a case, which had such marked peculiarities that I feel inclined to give a short synopsis of it."

The patient was a colored woman, 35 years of age. She had an excellent reputation and was a good church member. When she became ill, she applied to a prominent physician for treatment. After awhile, she called in Dr. Bunker. He was puzzled somewhat over the case. The patient suddenly took on a temperature of 104°. There was a great deal of hemorrhage in the abdomen and quite a large mass in the rear of the uterus. It appeared to be an infiltration of the cellular tissue. We curetted and were convinced that it was a case of abortion. The mass in the rear of the uterus continued to increase in size, but was neither soft nor fluctuating. It was quite a question whether we should open

it or not. The second day after we made the examination and did the curetting, they sent for us. When I arrived, the bed was soaked with pus and it stunk horribly. There were forty or fifty ounces. The woman was much prostrated. The second day afterwards, Dr. Bunker passed his finger and found some hard, bony substances. We removed a fetal skeleton. At the end of the second week the patient commenced to improve and now she is out."

Dr. Harold Brunn:—"The diagnosis of some of the cases of ectopic pregnancy are simple enough, especially if hemorrhage has occurred and we feel a mass on the side with pulsating arteries. Some cases are very difficult of diagnosis. The difficult cases are those that look like threatened abortions and you feel a mass on the side and there is a history of stopped menstruation. The question is whether there is a tubal pregnancy on the side diseased, or whether she has a pure pregnancy. The idea of curetting some of the membrane is not to be considered unless abortion is inevitable."

"The membrane of the uterus, in ectopic gestation grows and the tissue becomes enlarged and you have all the symptoms of a beginning pregnancy. Sometimes pregnancy of the uterus occurs along with ectopic gestation."

Dr. Levin:—"I would like to ask Dr. Barbat to explain the way a diagnosis in the early stage of extra-uterine pregnancy can be made. The membrane of the uterus, in cases of beginning fibrous tumors, can always show hyperthrophy with large cells having the appearance of those in pregnancy. The uterus may be a little enlarged, so that curettment and microscopical examination will give the idea of extra-uterine pregnancy, but will not be convincing."

Dr. Harrison: "A case came under my observation once which was extremely interesting. It shows the difficulty of diagnosing pregnancy without an examination. The case was diagnosed as 'normal pregnancy.' All the symptoms of normal pregnancy were present until full term had arrived. She then had labor pains, but no child appeared. She got over term a month and still the child did not appear. Her labor pains occurred every once in a while. She had fever soon and symptoms of septicemia. In making an examination, I found in the cul de sac of Douglas a hard mass, solid and feeling like a child's head. On making rectal examination, we found a fistulous opening between the rectum and the abdominal cavity and a hard mass presenting. We operated and removed a fetus partly decomposed."

The signs were so much like those of normal pregnancy that the physician did not think it necessary to make an examination."

Dr. J. Henry Barbat:—"I stated the method by which I arrived at my conclusions. I do not think that it is possible to make a diagnosis of extra-uterine pregnancy in such



early cases as these, unless there is a rupture of the tube producing discharge of blood into the pelvic cavity or broad ligament. The symptoms were those simply of hemorrhage into the abdominal cavity."

Dr. Kelly:—"In regard to the question asked by Dr. Strunsky, whether an early operation is always advisable, I think that the early operation should be done.

"In regard to the statistics of the cases treated by electricity, three of the sixteen cases reported in my paper proved fatal. Of those cases that were left to themselves, nearly eighty per cent proved fatal. The danger of rupture of the sac by use of the Faradic current is very great and I think it is unjustifiable at the present time, when, as has been already shown, opening of the cavity in extra-uterine pregnancy is free from septic conditions.

In regard to the decidua, I quite agree with what has been said by Dr. Carpenter concerning its microscopical appearance. The decidua in the extra-uterine pregnancy is much thicker and more liable to be an entire cast of the uterine cavity than in membranous dysmenorrhea.

"In regard to diagnosis, of course I think that what has just been said covers the ground very thoroughly. These symptoms are very characteristic and one is not likely to be mistaken. I have heard of many physicians who did not know that decidual membrane was thrown off in extra-uterine pregnancy."

#### RESECTION OF PYLORUS.

Dr. F. B. Carpenter reported a case of RESECTION OF PYLORUS as follows:

"This patient came to me some months ago. At that time he gave me a rather clear history of pyloric trouble but refused operation. Ultimately the trouble recurred, or rather continued, and he finally consented. He had characteristic symptoms of obstruction of the pylorus. Palpitation disclosed the presence of a mass to the right of the median line in the region of the stomach. It was rather hard and there was no room for doubt in regard to the diagnosis. With the assistance of Dr. MacMonagle, I operated. Upon opening the abdomen, I found the pyloric extremity of the stomach quite well over to the right. I made my incision through the right rectus. The mass was quite easily reached. It was movable and the lesser omentum was quite free from any sign of nodular growths. The only nodules to be found were in the immediate neighborhood of the pylorus. I determined to remove the thing because I felt that I could remove the entire pylorus easily and freely, and with it, all the nodules within reach. I was able to draw the mass pretty well out of the incision. I was obliged to make a four-inch vertical incision through the right rectus muscle. Before applying the clamps, I had ligated the lesser omentum and the two anterior layers of the great omentum. I think that in this part of the procedure lies

some of the success attending these operations. The mortality is alarmingly high, ranging from fifteen to fifty per cent. That includes, of course, all causes of death. In this instance, I was rather careful to preserve the arteries supplying the region from which this was removed. I was obliged to sacrifice the branch of the hepatic artery passing along the lesser curvature. The main branch I saved by cutting it off from the omentum, leaving the vessel in its continuity. The remaining structures were left with their full blood supply. After the greater and lesser omenta were tied off (I tied the greater omentum and perhaps one-third of the length of the stomach) in small portions, I then closed the entire cut end of the stomach by three layers of sutures, the first layer through the mucosa. That I closed with a continuous catgut suture. The next layer of sutures approximated the entire cut surface of the stomach. After that was finished, I invaginated it and put in an interrupted layer of Lembert's sutures over the whole length for security. After that was entirely closed I made an anastomosis between the posterior wall of the stomach and the cut end of the duodenum by means of the Murphy button. The approximation was very good. After the anastomosis was made, the man was sent to his room, and from that day until the time he was out of bed he never had a temperature above 99. He had rectal alimentation for the four days following the operation. I gave broths and liquid diet. I kept milk from him at first. Later on I gave mashed potatoes, rice and such vegetables as would give no accumulations of fibrous material. The man has gained and is getting along well.

Most anastomoses are made with the jejunum rather than with the duodenum. I think that where it is possible to do so, it is preferable to use the duodenum instead of the jejunum. If the jejunum is utilized, the portion of the duodenum, which is left for no other purpose than simply to carry the bile from the entrance of the bile duct to the jejunum, is going to atrophy from lack of use. We have records of cases in which impaction has occurred and which have resulted seriously. In picking up coils of jejunum, one should always be careful. Other portions of intestine have been picked up and opened and anastomosis made, which is not as satisfactory as anastomosis made higher up. It is not always easy to determine just what you have.

This operation is comparatively new. It has been done experimentally during this entire century, but only in an experimental way upon animals. In 1879 the operation was done upon a dog which afterward survived. In 1881 Billroth performed the first successful operation of the kind upon a human being. From that time on the operation gradually gained ground, although his patient died in five days. The next patient died in twelve hours but the operation became more or less successful from that time on. The mortality has been greatly diminished by the use of



mechanical appliances. The mortality has resulted, of course, from sepsis, shock, pneumonia and various causes, and is now reduced to about twenty per cent, which means, of course, all kinds of cases. The operation is necessarily often a long one."

Dr. J. Henry Barbat:—"One point might be mentioned in regard to anastomosis between intestine and stomach. If impossible to make appropriation with the duodenum and the stomach, it is preferable to cut the jejunum a few inches beyond its beginning (i. e., the beginning of the mesentery, opposite the body of the left second lumbar vertebra) and bring the distal end, anastomosing with the posterior wall of the stomach and then making lateral anastomosis with the proximal end of the duodenum. This brings the parts in practically normal relation to each other. In the other way, the bile and pancreatic juice pass into the stomach and cause a great deal of disturbance.

Dr. Carpenter:—"It occurs to me to call attention to the advantage of making an anastomosis on the posterior wall rather than the anterior wall of the stomach. One trouble has been that food has gravitated into one corner of the stomach and has caused trouble. With the anastomosis on the posterior wall of the stomach, the food tends to gravitate through the opening when the man is lying on his back."

## CALIFORNIA ACADEMY OF MEDICINE.

August, 1899.

### TABES WITH UNUSUAL SYMPTOMS.

Dr. Philip King Brown presented two cases of TABES WITH UNUSUAL SYMPTOMS. The history of the first case was as follows: Mrs. S., age 44½, first seen in May, 1899. She was married at the age of 18½ years, and subsequently gave birth to a normal child, still living and well. Three miscarriages followed, one at six weeks, another at six months and the last at three months; she has not been pregnant since. At the age of 19½, following the birth of the first child, she had what was called "ulceration of the womb"; this was treated with blue vitriol and cured. She had no further trouble from this source, nor has she ever had any headache, eruption or sore throat, save at one time, when in New York, she had headache, eruption, and other symptoms, which were said to be caused by sewer gas poisoning. At the age of 21 she had an attack of pleurisy, and 16 years ago she suffered from very severe neuralgic pains in the left hip, which seemed to be confined to the joint and lasted for five weeks, with occasional brief intermissions. At the age of 33 she first had dyspepsia, distress, accompanied by a great deal of gas, following everything eaten. This persisted for two years

and was followed by a period of three years, when she was well and comfortable, complaining of no physical ailments. At the end of this period of rest, nausea first made its appearance, lasting all day for a time, but latterly being present only in the early morning hours. After vomiting, relief is felt for the rest of the day. When the nausea appears during the day, if she can eat and then immediately lie down she experiences relief from the distress. For the past four or five years she has had occasional "girdle sensation." The sharp neuralgic pain, which appeared in the right hip 16 years ago, has returned from time to time; it is always referred to the same location, though at times the pain shoots down the right leg. In September, 1897, the pain appeared in the right heel; it was also neuralgic in character and would last all day with sharp exacerbations about every ten minutes. In February, 1897, she first noticed some dizziness, persisting day and night and worse when lying down. In March, 1897, while in a condition of fair health and comparative ease, the patient awoke one morning with the right pupil dilated; it remained dilated three days when she applied to Dr. Martin for relief. He instilled drops which contracted the pupil; it then remained contracted for three months, in spite of all efforts to dilate it. The left pupil then suddenly dilated and after two days slowly contracted to the present size; both pupils have remained contracted, as at present, ever since. Dr. Martin gave her potassium iodid and mercury. She later consulted Dr. Barkan, who gave her potassium iodid, 30 grains, three times a day. She next consulted Dr. Hirschfelder, who prescribed 300 drops of a 50% solution of potassium iodid, three times a day, and also gave her 36 inunctions of mercury. With the onset of the trouble in the left eye, the patient noticed numbness in the right foot and the left heel, both of which conditions have persisted since then, never disappearing, though at times becoming somewhat better.

The record of the patient, made two years ago, and filed in Dr. Barkan's clinic, is as follows: "The patient has diplopia in both eyes, especially marked when she looked down; there is paralysis of all the muscles of the eyes except the external recti; ptosis marked; the discs are normal." She complained of vertigo and could not stand with the eyes closed nor walk a chalk line; the hearing was normal. Some anesthesia was noted about the eyes, particularly above them.

She has never been constipated, but, on the contrary, has had occasional attacks of diarrhea, coming on with apparent cause, and lasting four or five days; these attacks have been noticed at times for a period of between four and five years. For six years past, she has been subject to occasional laryngeal crises, and pharyngeal crises have been of occasional occurrence for about the same time. During the pharyngeal crises she is unable to swallow while sitting up, but is able to do



so, with some effort, when lying down. These crises recur every few months. In May, 1899, she had, for the first time, a cardiac crisis, the pain strongly resembling angina, lasting for two days and somewhat paroxysmal in character. It was for the pain in the region of the heart that the patient called in the services of Dr. Brown, who then first saw the patient. His notes taken at that time show the patient to be a small woman, fairly well nourished, with no signs of eruption on the body, no motor paralysis and no anesthesia of the chest, on objective examination. The Argyle-Robertson pupils are present and the Romberg system is marked; the patella reflexes are greatly exaggerated, but the achilles and plantar reflexes are abolished. The Frankel sign is wanting. Examination shows the heart to be physically normal, no increased area, sounds normal, and no arterio sclerosis. The urine was normal and the stools showed the presence of much mucus. She was placed upon a treatment of 20 grains of iodid of potassium three times a day, together with inunctions of mercury. Up to August 5th, when last examined, the chest showed no anesthesia, though an area of partial anesthesia, about half an inch wide and extending down the inner side of the arms and forearms, was noticed; this is somewhat variable, but, on the whole, persistent.

"The stomach was frequently tested with the following result: Normally no hydrochloric and no lactic acid could be detected. The vomited material was slightly alkaline and showed neither hydrochloric nor lactic acid. After a test breakfast, following an attack of vomiting and hence when the stomach was empty, the result showed a faint reaction to litmus, no hydrochloric acid and a large lactic acid acidity. The stomach contents have been examined many times, but on no occasion has any trace of hydrochloric acid been found, and this in spite of all effort to stimulate secretion. A fairly well-defined girdle sensation has been present for some time previous to my examination."

The patient was presented and the various symptoms demonstrated. The Argyle-Robinson pupil was marked; the knee jerks were very evidently exaggerated, but the amount of incoordination was markedly small. Difficulty was evidenced in standing with the eyes closed and in walking a chalk line.

Dr. Brown said: "The case is reported for the reason that it seems a clear case of tabes presenting some very rare and unusual symptoms. The knee jerk is exaggerated instead of being abolished and this condition is extremely rare. The nature and occurrence of the various crises, too, is rather rare and unusual, and the amount of incoordination is much less than one would expect. The patient has the 'tabetic jaw,' all the teeth having suddenly fallen out some time ago. While this woman does not present a perfectly clear, classical picture of tabes, there are present so many distinct characteristics of that affection

that I feel justified in classing the case as one of tabes with unusual symptoms.

"Another case came within my notice in July. It also presented many symptoms of tabes, while at the same time many of the conditions present were unusual for that affection. The history obtained from the patient is as follows:

"Case II. Mrs. H., age 45, for the past four years has had attacks of pain in the region of the angles of the scapulae, lasting continuously day and night for two weeks at a time. Her past history is as follows: She was a strong, healthy woman up to the commencement of the pains mentioned, about four years ago. She has had several miscarriages, one 15 years ago at three months, and one two years ago at six months; she has had several children, the oldest being 17 and the youngest eight years old. One child died a year ago, at the age of three years; the patient had pains in the back three months before this child was born. She has had no headache, no sore throat; she has lost in weight in the past four years, falling from 145 to 95 pounds; much of her hair has fallen out during this time, but there is no history of other trophic disturbances. An eruption appeared on the body about six years ago, following the birth of a child, which is still living. The patient has not menstruated for the past two years. Four years ago, at the onset of the present trouble, attacks of nausea made their appearance and have been of daily occurrence since that time. The pain in the back is frequently relieved by vomiting; she has never vomited blood or coffee-ground material. The pain in the back seems to be worse after taking food and is aggravated by bathing.

"Examination shows the right pupil to be more dilated than the left and to react more quickly to light stimulus and accommodation. The knee jerks are abolished; incoordination is much more marked in the upper than in the lower extremities; it is slight in the legs. Anesthesia is strongly marked over the intermammary region. The anesthetic area is sharply defined, extends from nipple to nipple, and is about  $5\frac{1}{2}$  cms. in width. The patient is very constipated and has been so since the beginning of the present illness. For the past three or four months the bladder has been irritable. The epitrochlear, cervical and inguinal glands are all enlarged. The urine is pale, acid, 1020, trace albumen with hyaline and granular casts. Justus' test is negative, which was attempted on the statement of the patient that she had had no inunctions and, so far as she knew, no mercuric treatment. On the feet, especially the left foot, are found areas of irregular anesthesia, not corresponding to any nerve areas, and not constant. The speech is slow and at times slightly thick; patient states that this is always so. Is an exceedingly nervous woman and seems not to be altogether well balanced mentally.

"This woman has consulted a large number of physicians and has not remained under the



care of any one of them long enough to demonstrate the result of any one line of treatment. Dr. Moffit saw the patient some time ago and perhaps he will give us the benefit of his findings at that time."

Dr. Herbert C. Moffit said: I saw this patient in February of the present year. I gave her prescriptions for potassium iodid and mercury, but she did not again consult me. At that time she gave me a history that differs materially from the history subsequently given to Dr. Brown and just reported by him. What I gathered from her was substantiated and added to by her husband, who called upon me the day following her visit. He told me that she had had the abortions induced and that her trouble dated from the last one, which she had successfully attempted. She also said that the eruption referred to as following the birth of a child had appeared upon the child and not upon herself. The knee jerks were present at the time of my examination, the left one being somewhat livelier than the right. There was then no anesthesia on the chest and there was analgesia on the back. The incoordination seemed to be more of the nature of a muscular paralysis than anything else, and I noticed some wasting of the muscles on the left side. There were no other symptoms, of any particular importance, and I thought the case one of cerebro-spinal syphilis rather than tabes. There was also a large element of hysteria. The symptoms she spoke of to me, and the only ones which I elicited, were the pupils, the analgesia and the bladder affection; the husband spoke of lightning-like pains; there was nothing of the nature of the girdle sensation at that time. It seems to me that the knee jerks disappeared too rapidly for it to be a case of tabes. The onset, too, was rather sudden, and while there is nausea, there does not seem to be any definite crisis."

Dr. Brown did not agree with Dr. Moffitt, but thought it a case of tabes with rather unusual history and symptoms. The tabetic lesions would explain the symptoms and conditions as presented, and such diagnosis seemed more probable than cerebro spinal syphilis. "The cases were reported to the Academy," Dr. Brown said, "with the hope that they would draw attention to a, by no means, small class of cases that pass from one physician to another, the actual condition not often being diagnosed on account of the number of symptoms and their being masked to a greater or less extent."

Dr. Douglass W. Montgomery said that in mentioning the fact that many cases do so wander from one doctor to another, Dr. Brown had brought to his recollection an instance in point, and one akin to the cases reported. Dr. Montgomery said: "The history of the case, as I remember it, was about as follows: A man consulted me one day a few years ago, giving a history of nausea and vomiting, which had persisted for a long time, recurring at intervals and occasionally being

sufficiently severe to completely prostrate him. He had lost considerable flesh as a result of these attacks of nausea and vomiting. In his search for relief he had consulted a number of doctors, various diagnoses and opinions having been rendered by the gentlemen consulted. One opinion was to the effect that he suffered from an overfilling of the gall bladder, when then emptied into the stomach, thus producing nausea. He was sitting very near to me, at my right, as I was taking the notes of his case, when suddenly he clapped his hand upon my thigh and exclaimed 'There! Sometimes I have sudden pains, just like that!' referring to a pain in his leg which had very suddenly appeared. I was at once aroused, looked at his eyes, found the Argyle-Robinson pupil, and then extracted a fairly good history and picture of tabes. The knee jerks were absent, he could not stand with eyes closed, and he could not walk a chalk line. The sudden lightning-like pains had been in evidence for some time past. He was seen by Dr. Newmark and Dr. Sherman, who both agreed as to the diagnosis. I told him what the trouble was, that the nausea and vomiting were a symptom and would probably disappear after a time. Subsequently he had quite an adventurous life. He was trephined by one man, on account of an old injury to the head, he having been shot many years before. Later he submitted to a laparotomy for the purpose of examining the liver and stomach. When I last heard of him he was somewhat improved, for the stomach crisis had not occurred for quite an interval. This man's history is certainly apropos of what Dr. Brown said as to the many cases going about from doctor to doctor with the true cause of the trouble not understood or made out."

Dr. Harry M. Sherman said: "I saw this case with Dr. Montgomery, and I think there can be no question as to the fact that the man has tabes. He had been frequently exposed to syphilitic infection, though I do not remember whether a history of syphilis was obtained from him. A rather curious fact in connection occurred in my own experience. I was treating a child of this man for what I supposed was hip joint disease. But the joint trouble improved so rapidly that I was forced to abandon the diagnosis. Very shortly after the child got well and left my hands, I learned of the syphilitic trouble with the father and rather concluded that the hip joint affection was the result of syphilis. But a short time afterwards I treated a child for spinal disease; what I thought was tuberculosis of the spine. He did very badly, much to my disappointment, and finally left me. In speaking of the case to Dr. Montgomery somewhat later, I learned that the father of this second child was a syphilitic and the conclusion that here, too, the trouble may have been of syphilitic origin was forced upon me. These two cases form a distinct class in my mind. In both cases the diagnosis, at first apparently clear, had to be given up, and in



both cases I later learned that the father was syphilitic and had been so for years."

PLASTER OF PARIS AS AN AID IN THE TREATMENT OF FISTULAS.

A communication from Dr. J. F. McCone was read, who was unfortunately prevented from being present himself and presenting the matter in question in person. The communication set forth what Dr. McCone thought to be a new method of surgical procedure, and one which certainly was original with him. The suggestion of Dr. McCone was that, in ischio-rectal fistulas the fistulous tracts and canals be injected with soft dental plaster of paris, that it be allowed to harden, and that the fistula and its ramifications could then be more easily and effectually dissected out, leaving a clean, fresh wound, which would heal by first intention. He had employed the method in one case with entire satisfaction and requested that it be tried by other members of the Academy and the results considered.

The novel method of locating fistulous ramifications suggested by Dr. McCone was discussed at some length. Dr. Dudley Tait, who, at the request of the Chair, read Dr. McCone's communication, thought that in its present shape the subject was not in the best light for discussion; Dr. McCone had not entered sufficiently into the special feature he advocated and the previous treatment of the case reported was decidedly open to criticism. He would suggest that it be referred back to Dr. McCone for his revision and presentation at a future meeting.

Dr. Montgomery, the president, stated that it was at his personal request that Dr. McCone had sent in the communication read. He had requested the doctor to do so in order to secure a record of publication of the method employed, which seemed to be original, and thus not run the chance of loss of priority of an improved procedure.

Dr. Philip King Brown was inclined to doubt the possibility of injecting all the ramifications of a fistula with the plaster, for the reason that they would be, in all probability, already filled with debris, broken-down tissue, etc., and hence the plaster would not penetrate the canals far enough and well enough to be of any unusual value. He also called attention to the fact that many of these sinuses were of tuberculous origin, and, such being the fact, in any given case, it would not be possible to remove all the tissue involved, even should the plaster penetrate all the sinuses. The tuberculous involvement would be more extensive than the sinus. If sufficient force were employed to inject fully the sinuses, he was of the opinion that damage could result.

Dr. Herbert C. Moffitt called attention to the fact that forcing the plaster into the sinuses by pressure would possibly induce more extensive septic infection through the forc-

ing of the septic germs into the surrounding and healthy tissue, where absorption would be rapid, perhaps resulting in a general infection.

Dr. Tait suggested that the plaster might penetrate, under the pressure employed, tissue not diseased and that hence a greater amount of tissue than necessary might be removed in the subsequent operation. He called attention to the fact that the simple excision of fistulous canals was not at all a new procedure; that for a long time it had been a recognized surgical practice to treat such fistulas by complete excision, the wound healing by first intention.

Dr. Harry M. Sherman referred to the injection of arteries by plaster of paris, in which process the force required to completely inject even the smallest arterioles was not great. He thought that a fistula could be as easily injected; the secretions and debris that might be present in the canals offering little or no objection to the process. In considering the possibility of inducing a general infection, it must be remembered that fistulous canals are surrounded by walls of thickened tissue, often very dense, and that the small pressure required would scarcely force the disease germs into the healthy tissue surrounding the fistula's wall. There would also, in all probability, be a regurgitation of the contained material, the plaster solution being permitted to penetrate all the diverticula.

Dr. Harold Brunn said that the method seemed to him to be a most unique method of dealing with a very troublesome condition. It is at best exceedingly difficult to locate all the diverticula and ramifications of a fistula. The method suggested seemed to give promise of making this somewhat easier, and while it might be open to objections, it certainly presented many excellent features and was well worth a trial.

CANCER OF OVARIES.

Some specimens of cancer of the ovaries, with microscopic slides, were presented by Dr. Harold Brunn. The two ovaries removed from one woman showed very clearly the cancerous nature of the involvement. The right ovary had been the site of a large ovarian cyst, some 13 pints of fluid contents having been drawn from it prior to removal. On the inner surface of this cyst wall were numerous nodular masses, from the size of a pea to masses larger than a hen's egg. Some of these masses were papular in nature, but most of them showed clearly the cancerous formation of the tumors. The left ovary of the same woman was purely cancerous; it was with difficulty dug out, together with another cancerous mass in the omentum.



# ALAMEDA COUNTY MEDICAL ASSOCIATION.

July 29, 1899.

Dr. J. S. Adams died July 29th. The Alameda County Medical Society attended the funeral in a body. On the following Sunday, August 6th, a special meeting of the society was held to do honor to his memory. Eulogies were read by Drs. Bradway, Pratt, Overend and Maher. Dr. H. N. Rucker, chairman of a committee appointed for that purpose, presented the following resolutions of respect and condolence:

"Death has again invaded the ranks of the Alameda County Medical Society and claimed one of the oldest, most conspicuous and honored members.

"It has been said: 'Old men for counsel, young men for action.' Dr. J. S. Adams was filling both these spheres to a remarkable degree at the time of the sudden summons which called him home; ever ready with wise counsel and wholesome advice, ever ready for action when duty called.

"He loved the profession of medicine and kept pace with its advancement. He labored patiently and bore uncomplainingly the cares and responsibilities incident to his professional life, because it pleased him to alleviate suffering and to bring cheer and comfort to the afflicted.

"He held the respect and confidence of the community, because he deserved it. He possessed to an eminent degree, by birth and education, the peculiar qualifications of the physician.

"If he had faults they were not of the heart. Sordid aims were beneath his mental horizon and pecuniary gain was not the mainspring of his action. Self-sacrifice, patient toil and devotion to duty were characteristics of his daily life, and this Society could ill afford to lose him.

"Whereas, in the death of Dr. J. S. Adams, this Society has lost one of its most honored and useful members; his family a tender and affectionate husband and father; society at large, an able physician and highly esteemed citizen, whose character and example were worthy of imitation; therefore be it

'Resolved, That we deeply sympathize with the sorrowing family in their great bereavement, and pray that the 'Great Physician' may soothe and comfort the hearts made desolate by this sad affliction.

"Resolved, That the above be made a part of the minutes, and a copy thereof be forwarded to the family in token of our sympathy and sorrow

H. N. RUCKER,  
S. H. BUTEAU,  
A. H. PRATT,

"August 6, 1899.

Committee."

## BOOK REVIEWS.

INTERNATIONAL CLINICS. A Quarterly of Clinical Lectures on Medicine, Neurology, Surgery, Gynecology, Obstetrics, Ophthalmology, Laryngology, Pharyngology, Rhinology, Otology and Dermatology. Edited by Judson Daland, M. D. (Univ. of Penna.), Philadelphia. J. B. Lippincott Company, Philadelphia, 1899.

The first volume of the ninth series of the International Clinics comes with much that is good, and the entire number is of the same high standard that has made the other volumes valuable.

Horatio C. Wood, M. D., LL. D., is the author of a chapter on "Cold as an Antipyretic," and, while the chapter is not long, it gives the indications for the use of the cold bath, cold pack, tepid bath, cold air bath, etc.

Another interesting chapter is that on "The Valvular Diseases of the Left Heart," by Dr. J. N. Hall. G. W. McCaskey, A. M., M. D., contributed an instructive article on "Anemias of Intestinal Origin; Report of a Fatal Case with Autopsy." In "Neurology," G. L. Walton, M. D., is the author of the section entitled "Paralysis of Isolated Branches of Ocular Nerves Produced by Trauma; Obstetrical and other Brachial Plexus Paralysis."

Alexander J. C. Skene, M. D., LL. D., furnishes the chapter on "The Use of Electricity in Surgery," with cuts of his electro-hemostatic forceps and indications and directions for their use. The entire volume is one of modern scientific articles contributed by able men.

### THORACIC RESECTION FOR TUMORS GROWING FROM THE BONY WALL OF THE CHEST.

By F. W. Parham, M. D., Professor of General and Clinical Operative Surgery, New Orleans Polyclinic, 1899.

In a monograph of one hundred and fifty pages, the author has collated more than fifty cases illustrative of the subject. The value of the work done is self-evident.

The propriety of opening the pleural cavity and removing a considerable area of the outer wall has been definitely settled. The technic of such procedure is gone into extensively, and for clearness and explicitness the volume is a notable production. It can safely be said that with the knowledge contained in this monograph the operator will be able to meet the perplexities arising in this class of cases with far greater assurance. The volume is admirably illustrated, and appended are several tables, which, for purposes of reference, will be found of great interest. The paper was read in abstract before the Southern Surgical and Gynecological Association at Memphis, Nov., 1898.



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## READING NOTICES.

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### LA GRIPPE.

ITS MANIFESTATIONS, COMPLICATIONS AND  
TREATMENT.

By W. W. Grube, A. M., M. D., of Toledo, O.  
Professor of Physiology and Clinical Medi-  
cine, Toledo Medical Col-  
lege, Toledo, Ohio.

Abstract from the *Journal of the American Medical  
Association*, March 25, 1899.

Professor Grube sees no reason why the  
intelligent observer need err in his diagnosis  
of la grippe; he believes that the intensity of  
the catarrhal symptoms, the great prostration,  
and tardy convalescence form a typical clinical  
picture. Though the catarrhal symptoms are  
usually limited to the respiratory mucous  
membrane, they are not always so, and in the  
writer's experience the invasion of the mu-  
cous membrane of the digestive tract has been  
quite frequent. Not alone mucous mem-

brane, but a part or all of the cerebro spinal  
axis has been invaded.

In many cases the so-called complications  
are simply an extension and aggravation of  
the catarrhal or inflammatory condition;  
thus an extension of the usual inflammatory  
condition of the throat through the Eusta-  
chian tube produces middle-ear complications;  
the bronchitis, too, may extend and become  
capillary, or even a pneumonitis may result.  
So we believe that in the so-called abdominal  
form with severe gastro-enteric catarrh, it  
may extend by *contiguity* and inaugurate a  
general peritonitis. Upon this theory alone  
can we explain the supervention of a severe  
peritonitis in a case under our care, now hap-  
pily terminating in convalescence.

The patient was a girl of 11 years who had  
never been seriously ill before. Twenty-four  
hours after the illness began, she had, be-  
sides the usual alarming symptoms of la  
grippe, a high temperature, wild delirium,  
constant emesis, frequent and copious dis-  
charge of feces and urine. The appropriate  
remedies were prescribed, the vomiting  
ceased and she rested; but on the third or  
fourth day she developed symptoms of peri-  
tonitis, abdominal pain, hardness and some  
tympanites, etc. Calomel was prescribed,  
twenty grains divided into four powders, one  
every three hours; also the usual turpentine  
stupes, morphia to quiet pain, etc. The next  
day, finding no improvement, but rather ag-  
gravated symptoms, green vomit, bowels not  
moved—a very gloomy prognosis was given,  
and at the family's request a consulting physi-  
cian was called, who concurred in diagnosis  
and prognosis, and had nothing more to sug-  
gest. On the writer's return in the evening,  
however, he decided in view of the great  
mortality of these cases by the routine treat-  
ment, to try the local application of a mustard  
poultice; also, for their germicidal, antiseptic  
and healing qualities, he gave internally Hy-  
drozone diluted, in frequent doses, alternating  
with doses of Glycozone. In twenty-four  
hours there was slight improvement. In for-  
ty-eight hours the patient was decidedly bet-  
ter. Improvement continued, and the girl  
was so well February 21st that she was dis-  
missed as cured.



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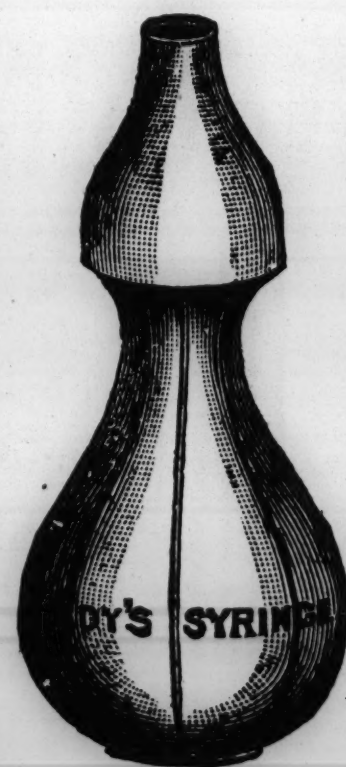
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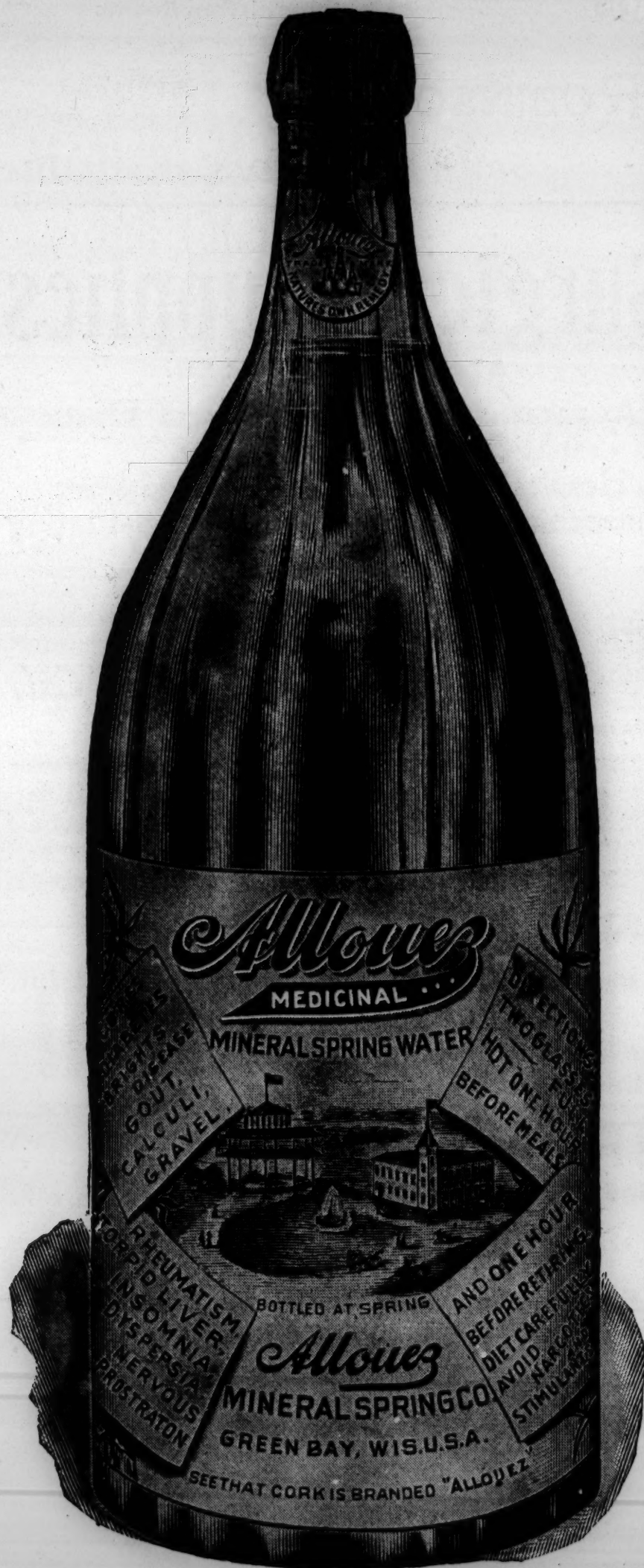


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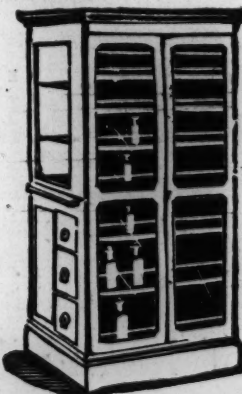
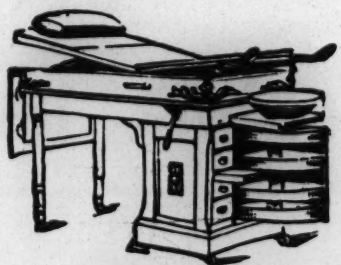
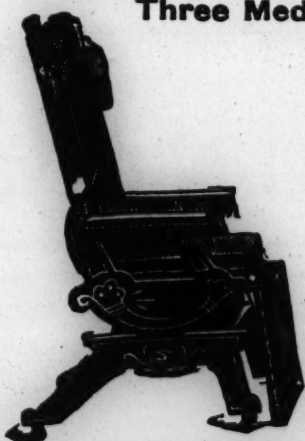
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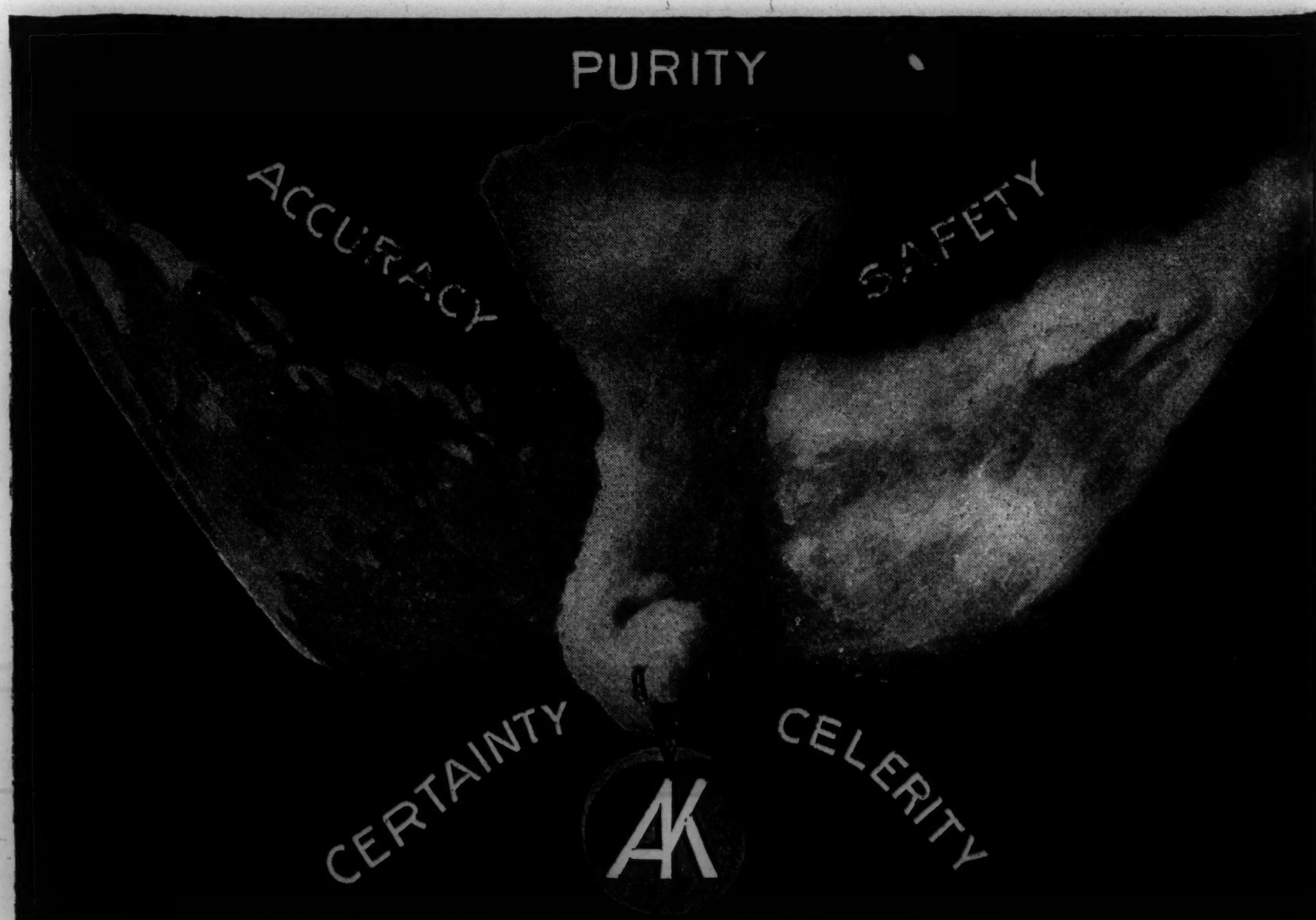
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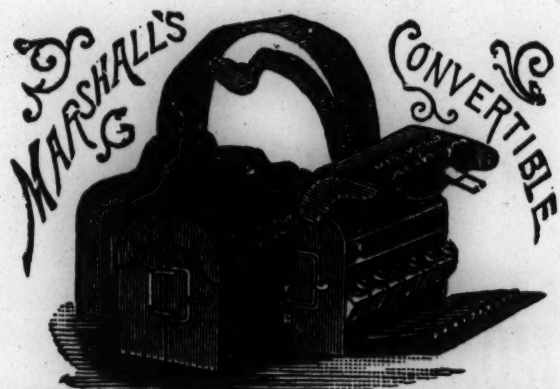
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PRELIMINARY TERM COMMENCING OCTOBER 2, 1899.

REGULAR TERM COMMENCING NOVEMBER 1, 1899.

GILBERT M. BARRETT, A. M., M. D.,

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For Annual Announcement, or other information, address the Secretary at the College.

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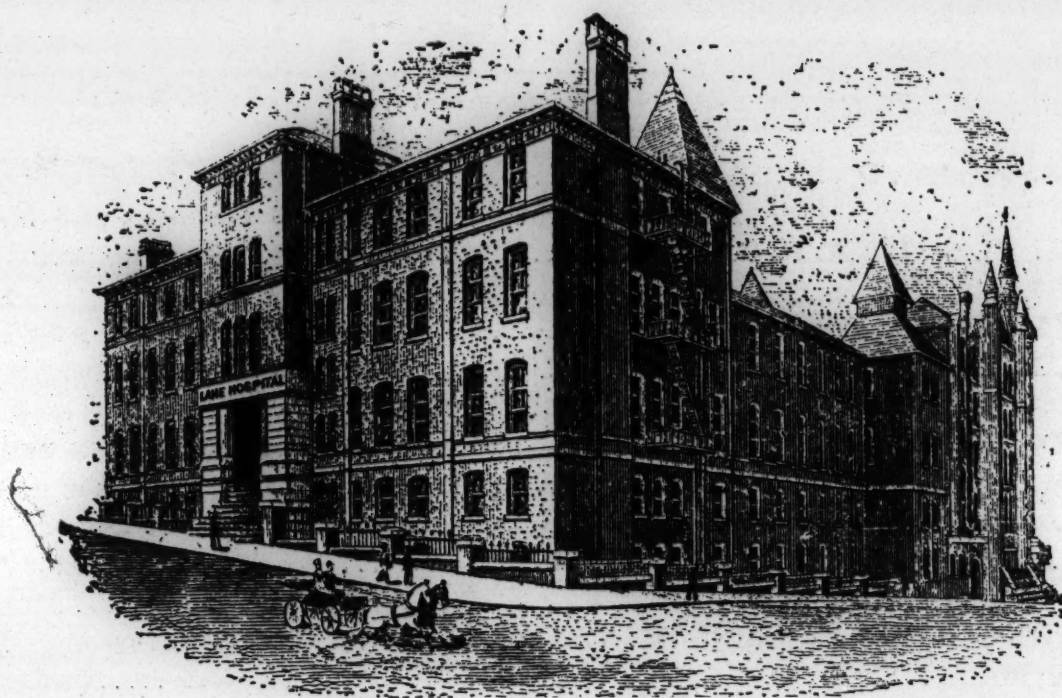
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| WM. B. LEWITT, M. D.....                             | Associate Professor of Diseases of Children                     |
| F. T. GREEN, Ph. G.....                              | Associate Professor Medical Chemistry                           |
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 HARRY P. CARLTON, D. D. S.....Lecturer on Operative Dentistry  
 H. R. WILEY, A. B.....Lecturer on Dental Jurisprudence  
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 H. D. NOBLE, D. D. S.....Instructor in Orthodontia Technic  
 H. C. HAUSELT, D. D. S.....Instructor in Clinical Mechanical Dentistry  
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